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Iris Zavala
University of Massachusetts Amherst

IDENTIFYING MENTAL HEALTH NEEDS IN AN HISPANIC COMMUNITY: TOWARDS A PARTICIPATORY METHODOLOGY

A Thesis Presented

by

IRIS ZAVALA MARTINEZ

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IRIS ZAVALA MARTINEZ

Approved as to style and content by:

Castellano Turner, Chair of Committee

Harold Raush, Member

Howard Gadlin, Member

Charles E. Clifton, Jr., Department Head
Psychology

DEDICATION

This project is dedicated to the Puerto Rican community and to their struggle towards self determination and participation in their social and personal history.

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Appreciation of dialectical processes compels us to recognize interconnected and dynamic relationships. Applied here this means that there are a number of persons whose vision, support, help, and patience must be acknowledged.

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INTRODUCTION

Overview of the Problem

The task of determining the needs of a community precedes the possibility of planning services or developing relevant social programs and action for that community. The approaches used in the assessment of community needs respond to methodologies that are informed by theoretical frameworks containing particular implications as to their implicit purposes. Historically, the methods which have been used are characterized by the relative, if not total, lack of participation of the community in this assessment process. The outcome of these methods which intend to develop programs for the community, while negating active community participation, is to maintain people as marginal and passive recipients of these services and to maintain an oppressive and colonizing ideology. Such methods serve the purpose of controlling people and legitimizing the present social order (Aponte, 1978). They are hierarchical and non-participatory, and in relation to the minority communities in the United States they further contribute to an alienating reality which not only mystifies the sources of conflict and stress in community life, but also fosters oppressive experiences and relationships.

Even though the community mental health movement held promises of community participation and community control, its thrust has been co-opted (Nassi, 1978). As an initial step towards active community planning, methods of increasing community control and participation

in the assessment process need to be developed. Such a project, however, would have to differ radically in its methodology and theoretical orientation from models that legitmize the alienating social order. Such a project would need to be informed by a methodology whose theoretical underpinnings would imply striving towards liberating activity and the development of critical consciousness. This methodology would be consistent with active participation of people in the areas that affect them, and would integrate theory and practice with the research endeavor. These features are consonant with the Marxist concept of praxis, a philosophical orientation which necessarily embodies a different and critical understanding of human activity and the research process. Praxis provides a theory of action and of human activity which develops from dialogic matrices (Freire, 1973b). Within this conception human beings are active producers and transformers of nature, of the social world and of themselves. In praxial activity human beings are both subjects and objects of their historical situation and consequently in control and conscious of their experience. Within this conception the basis and possibilities for the development of critical consciousness and self-determination are potentiated while sustaining an emancipatory project. Likewise, this orientation is grounded on a critique of the existing constraints to such a project. This study attends to the fundamental implications of this theoretical framework.

The problem in this study relates to exploring a method of increasing participatory decision-making processes which mobilize people

to appropriate their own practice while developing in the process a more critical consciousness about their lives and social reality. Consequently, the research method corresponds to this orientation and embodies a conception of scientific investigation which is committed to the active participation of community members and to the benefit of the participants and the community in both the process and the research outcomes.

More concretely, the problem was one of searching for ways to integrate the actual development of a survey instrument that would assess the mental health needs of a community with the active participation of community members, specifically Hispanic youth in a time-limited training and work program. Therefore, the problem addressed is threefold:

1. The design of a participatory research model which would integrate active community participation (wherein the researcher is part of the community) with a training process for Hispanic youth partially drawn from that community, with the concrete development of a survey instrument for assessing the mental health problems and needs of that community.

2. Operationalizing the participatory research design.

3. Analyzing specifically the data collected to identify the mental health needs of the Puerto Rican community as a basis for program planning and development.

The problem of how to assess the problems and needs of a community, oriented by praxical activity and participatory research, generates a

methodology which benefits a community in process and in results, rather than benefitting exclusively the academic pursuits of the researcher.

Purpose of the Study

The purpose of the study is fourfold. First: to design a research model which could integrate a participatory approach with assessing community needs. The questions to be addressed are how can the mental health needs and problems of an Hispanic community be identified informed by the concept of praxis and how can this model potentiate the concept of participatory democracy given the involvement of Hispanic youth? Also as a part of this model, what training process would have to be developed which would be consistent with the conceptual orientation and with the development of the research instrument to identify needs and problems in the community?

Second: to field test the model within a participatory research study. Given the possibility to operationalize the design with Hispanic youth partially drawn from the community, what essential procedures need to be integrated in the actual training so that the instrument can be field tested in the community? What essential characteristics of participatory research must be incorporated to insure a consistent project? What problems and limitations emerge in the process of field work?

Third: to analyze the collected data from the Hispanic community on the mental health needs and their correlates. The questions to be

addressed here are to what extent the Puerto Rican community under study is faced with particular mental health problems and needs, and what are these problems related to. Also, do the data suggest any special characteristics about this community and their mental health given other studies on the mental health of Hispanics, particularly Puerto Ricans?

Fourth: to benefit the participating researchers in the process and to produce findings relevant and useful to program development and planning for the community. The relevant questions to be addressed here are whether the needs survey provides data for community decision-making and whether it is useful in identifying their needs. Also, is there evidence that the participating researchers developed skills they did not formerly have? Are there suggestions that the participants developed more critical consciousness about themselves and their social reality?

Significance of the Study

This study is an attempt to explore and to contribute to research practices that evolve from a critique of prevailing approaches which function to legitmize oppressive social experiences and relations. As such it is an endeavor to contribute to dialogic participatory research practices and ideas which are committed to generating liberating social experiences and participatory social action. Clearly, this study is of a preliminary and explorative nature, yet it can help mobilize interest and further inquiry into the possibili-

ties and limitations of a participatory research approach not only for the assessment of needs, but for other community mental health activities.

Specifically, this is an effort to integrate levels of action into one interactive model which should result in a particular service to a community. This is not only an integrative attempt, but one which recognizes the dialectical nature of activity and the need to unify theory and practice. This recognition implies an awareness that this research is dialogical, that it responds to a historical and social context which structures the reality that in the very process of research is revealed and described. It endeavors to actively discover with the community members the problems and needs that they experience in their daily lives engaging through this collaboration, in the recognition that people have the potential to define their needs, develop an awareness of a problematic life situation, and begin to move towards transforming their reality.

Finally, part of the significance of this study relates directly to the particular population it is addressed to. The mental health needs of Hispanics in the United States, and of Puerto Ricans in particular, have not been thoroughly studied nor documented enough, although a tendency exists to consider this population as one "at risk" (President's Commission on Mental Health, Report, 1978). Likewise, in the geographical area under study, documentation of problems and needs in mental health is lacking. It is hoped that this study can provide an approximation to identifying those problems and needs that affect this Hispanic community towards achieving necessary services and programs.

C H A P T E R I I

LITERATURE REVIEW

Praxis and Participatory Research: An Orienting Framework

In order to bring into relief the contextual panorama which potentiates and informs a dialogic participatory project, a brief review of the philosophy of praxis followed by a discussion of the concept of participatory action is in order.

The Marxist concept of praxis, the Greek word for practice, provides a philosophical orientation towards describing the dimension of human activity and its impact on the development of consciousness and the socio-historical world. Marx (1978) in his often quoted "Theses on Feuerbach" written in 1845 states that:

> Social life is essentially practical. All mysteries which mislead theory into mysticism find their rational solution in human practice and in the comprehension of this practice (p. 145).

Implied by praxis is the forging of theory and practice, of ideals and reality, whereby human activity is reciprocal and constantly creating and recreating the social world and those engaged in that activity. Praxis then embodies a continual process of transformation and change. Kosik (1967) defines praxis as "...the determination of human existence as transformation of reality (p. 240). Further Kosik asserts that in this praxis, humans produce the material world, the social relations and conditions, and from these their ideas, emotions and other human qualities. For Kosik praxis is "the sphere of the human being" and an

"auto-creative process" in which the social being creates reality and interprets it in a particular way. In Sanchez Vazquez's (1977) study of the philosophy of praxis he concludes considering:

> ...praxis as material, human activity that transforms both the world and man himself. This real, objective activity is at once ideal, subjective and conscious...Praxis presents itself in various forms, but all concur in their transformation of a given raw material and the reaction of a world of human or humanized objects...social man himself (p. 332).

Bernstein (1971) phrases the significance and ramifications of praxis in even clearer ways. He reminds us that:

> Marx had a profound understanding of the ways in which men are what they do, of how their social praxis shapes and is shaped by the complex web of historical institutions and practices within which they function and work (p. 306).

Further, Bernstein describes Marx's project as one which called for critically understanding the human condition. In such a way:

> We could resolve the 'paradox' of social praxis by discovering the ways to create institutions that would no longer alienate us, but foster the rational, free creative development of individuals....Marx, we might say, was articulating a new paradigm for describing, understanding, and eventually changing the quality of human life. It is a paradigm shaped by his understanding of the nature, dynamics, and consequences of human activity--praxis (p. 308).

Bernstein's excitement with this paradigm is that it provides a perspective, an orientation to the conflicts and contradictions in a contemporary society. Similarly Freire's works (1972, 1973a, 1973b) are based on this orientation. Freire, however, goes beyond inquiry to the generation of a pedagogy concerned with an "humanist and liberating praxis" which provides a theory of action and human activity developing from a dialogic matrices (Freire, 1973b). This implies the dialogical engagement of human beings in the unfolding of their experience. It

implies the active determination and control of social life and action, whereas its contrary would be domination. Praxis can be a source of knowledge and a way of studying reality. This informs Freire's conception of research methods (Freire, 1974). He states that in order to know a reality, a concrete reality:

> consists not only of concrete facts and (physical things, but also includes the ways in which the people involved with these facts perceive them. Thus in the last analysis, for me the concrete reality is the connection between subjectivity and objectivity...then I have to use methods for investigation which involve the people of the area being studied as researchers. They would take part in the investigations themselves and not serve as the passive objects of the study... (but) dialogically involved also as subjects, as researchers with me....This method of investigation...is at the same time a pedagogical process. Through this process of investigation, examination, criticism and reinvestigation the level of critical thinking is raised among all those involved (pp. 134-135).

This method then fosters dialogue, reciprocity and active participation and is based on a different conception and understanding of human beings: one committed to emancipation. This vision of research, based on praxis, provides a methodological approach for participatory investigation (Aponte, 1978; Ander-Egg, 1973) which is committed to liberating social action. This implies an approximation to the realization of participatory democracy. Benello and Roussopoulos (1971) state that in:

> a participatory democracy, decision-making is the process whereby people propose, discuss, divide, plan and implement those decisions that affect their lives...Participatory democracy assumes that in a good society people participate fully...Participation and control must be one. Furthermore, the dmocratic process of participation and control must be used in the movement for social change...thus the means employed for change must be democratic (p. 6).

Research committed to the vision of participatory democracy, to social

change and consciousness raising presents a challenge to traditional social science enterprise. It challenges the role of the researcher, the approach to the problem under the study, the research benefits and the purposes of the results and conclusions. Ander-Egg (1973) affirms that what is involved is "...not a militant investigative process, but a militant practice" (p. 102) which implies certain commitment and solidarity. Aponte (1978) elucidates this further when he writes:

> The primary purpose of participatory research is to politicize the people involved through consciousness raising...(where) the research process and the results...should be of some immediate and direct benefit to the participants...that the participants gain not only from the results of the research, but from the project itself...(pp. 65-66).

Further he asserts that:

> Consciousness of alienation and powerlessness can be built only on the change oriented and critical re-creation of the everyday lives of people (p. 66)...which services to establish community needs and increase awareness (p. 67)...(and) stresses the potential ability of people collaboratively to define and solve the problems they encounter (p. 70)...

Although this brief delineation of the inter-relationship between praxis and participatory research can obscure the complexity of some issues, it provides an essential orientating framework for this study. Additionally, considering the population under study, a minority group, this framework obtains an added dimension. Minority peoples in the United States have experienced domination and oppression as a fact of everyday life. The lives of poor Puerto Ricans are no exception. The consequences of these experiences may generate attitudes and functional styles which further accentuate their powerlessness and marginality. Ander-Egg (1973) asks, "Why and for what should we strive for the inte-

gration and participation of the marginated in a society that in itself produces marginality?" Although contradictory in content, this very question can also be instructive in purpose. There may not be a precise answer, but the struggle to emerge from this dominated role is part of the strivings of participatory research. For the minority person, colonialized and powerless, research can be another tool of colonialization and perpetuation of the status quo. Recent scrutiny of research on minority peoples in the United States reveals a needed and refreshing trend.

Slaughter (1973), Barnes (1970), and Comer (1970) have all pointed out problems with some of the research on minorities. Herzog and Lewis (1971) state that the minority community is rebelling against "proliferating questionnaires and swarming investigators." Particularly when many of the "scientifically objective" conclusions are essentially racist and have reneged in contributing to changing oppressive conditions or promoting relevant needed services. Baca Zinn (1979) states it this way:

> ...inappropriate assumptions and frameworks have produced distorted accounts of minority group life...the relationship between social researchers and the people they study has been unequal at best and exploitative at worst: researchers take information and eventually receive professional advancement but the minority people receive nothing for the time and information they provide (p. 209).

Although she points out the difficulties of insider or outsider research in minority communities, and although she calls for "a social science which has liberating rather than oppressive ramifications" in its research activities, she does not explore a participatory methodology. However, the actual state of research and the state of life in minority

communities compel further explorations into a research practice that can simultaneously render meaningful and beneficial results while promoting community growth and social consciousness.

Assessment of Needs

The purpose of a needs assessment is to provide data for decision making in order to develop and plan programs. According to Attkisson, Hargreaves, Horowitz and Sorensen (1978):

> Need assessment is the effort to determine the appropriate mix of human services for a community and to detect important gaps in these services (p. 468).

Needs assessments respond to the awareness that in order for social programs to be accountable to a community, the designers of such programs have to know the needs and demands of that community. Often needs assessments are seen as a systematic method of communicating to planners the community needs (Thomann, 1976), and the identification of these often reflect the problems that a community may have. Nguyen, Attkisson, and Bottino (1976) define an unmet need:

> An unmet need is said to exist when a problem in living, a dysfunctional somatic or psychological state, or an undesirable social process is recgonized, for which a satisfactory solution requires a major mobilization of additional resources and/or major reallocation of existing resources.

Goodenough (1963) states that:

> Practically speaking, what a community needs is not so much a matter of fact as a matter to be negotiated (p. 58).

This recognizes that the unmet social needs of a community are more an issue to motivate action toward their being satisfied. Practically speaking, then, a needs assessment can only reflect the social and

collective situation of a community. An investigation into the needs and problems will portray a social reality that has to be taken into account when particular services for that community are organized or when changes in pertinent policies are at stake.

According to Glish and Brennan (1977), the methods of needs assessment that have often been used are:

Community survey--home interviews, phone interviews, mail questionnaires.

Social-economic data--demographic information as part of a survey from available records (social indicators are socio-economic data).

Service provider input--asking program administrator or staff their views on needs either by a survey, an interview or a task force.

Existing agency records--information gathered from records of those being served in order to gain an estimate of need.

Inventory of mental health agencies and programs--a listing of existing agencies and their program description.

Task force--composed of representation from the area to insure expression of different groups which can use any of the previous methods.

Community forum--an open community meeting where the community discusses its needs.

As Thomann (1976) points out, most of these needs assessment methods are not designed for community participatory or planning purposes. The community surveys are passive instruments veiling indirect control, although quite often the preferred method as attested by the

number of surveys done either by home or phone interviews or mailed questionnaires. However, the community survey can involve the community depending on the orientation of the study. The socio-economic data approach is technical in orientation even though the use of social indicators is seen as plausible in community development. In a project merging issues of personal and social well being with attempts at policy change, Todd, et al. (1978) state:

> The concept of a stable and responsive set of measures of well being as a basis for formulating and evaluating policy decisions is an attractive one, and there seems to be a renewal of efforts to establish and validate such measures. Unfortunately, the model seems most often to be a passive one in its conception of action or change; it simply provides information to the established decision process.

Though they recognize the limitations of social indicators, they likewise reasoned that "widespread citizen input to the formulation of social indicators in one democratizing influence..." The issue, however, remains that the ultimate use of democratized social indicators is controlled by the powers that be. The service provider input approach depends on the views of agency staffs which can open the data field to a series of misconceptions and erroneous information as to the community need. Relying on this method ignores the fact that many clients in need often would not come close to a community agency as is often the case with Hispanics (Padilla, Ruiz, and Alvarez, 1975). Exploration of existing agency records likewise suffers from the same limitation, that is, that not necessarily those being serviced are an index of the only ones in need. The inventory method which lists agencies related to a particular service cannot be a measure of the met or unmet needs in a com-

munity. The task force approach which brings together either expert consultants, or community interest groups representatives, or service providers, though possibly effective in identifying the community's need, still corresponds to a hierarchical orientation which can eclipse a community's reflective and action orientation. The last approach, the community forum, has the advantages of providing an open-public arena for discussion and dialogue about the problems and needs in a community, although it also has the disadvantage of obscuring a specific exploration of some particular need given its public format.

These different approaches to identifying needs respond to the orientation of those interested in the project, to the area or sub-population is to be covered, to the questions being asked and to the motivating reasons underlying the study. The issue, however, is that the method of choice will respond to that theoretical orientation which either implicitly or explicitly is adhered to.

In the area of mental health, the development of community mental health programs has necessitated the assessment of needs as stipulated by the 1964 Federal Regulations for the Community Mental Health Centers Act. These regulations call for the assessment of a community's mental health needs as preceding systematic service delivery. The prevalent indices of need, for these purposes, have been epidemiological studies (a variation of the community survey) which have, however, encountered problems in estimating prevalence from data such as hospitalization rates, outpatient clinic services, referring sources and even indices such as poverty, social pathology and population subgroups. The dif-

ficulties and possible uses of these data in assessing mental health needs are summarized by Schulberg and Wechsler (1967), who describe part of the problem of the assessment tasks. In a survey of needs assessments "relevant to mental health issues" by Glish and Brennan (1977) in the Franklin/Hampshire areas these authors identify approaches used, agencies involved, areas covered, results obtained, and suggestions for future assessment of needs. They found disproportionate representation by area and sub-groups, lack of broad area wide studies, and choice of methods. Of interest to the present study is that not one study focused on area minority groups, particularly the Hispanic community and not one incorporated the community forum approach although a variety of the community survey was the most frequently used approach, followed by agency records and socio-economic data. The present investigation attends to these three concerns in an integrative way in order to identify salient mental health needs.

Training Indigenous Youth

The literature of community mental health cites numberous examples of training projects and programs for indigenous "non-professional" workers (Rappaport, 1977; Heller and Monahan, 1977; Reiff and Riessman, 1965). The shortage of person-power is often cited as a basic motivating factor as is the search for improving the delivery of helping strategies and its relevance to the population in question. This focus reflects a changing conception of personnel involved in community mental health and an embracing of the theoretical notion that "people learn

more readily from their peer-group than other groups" (Sobey, 1970). Although debate continues as to the effectiveness of the indigenous non-professional, there is a recognition that such roles improve self-concept, serve a rehabilitative function, increase social awareness and provide a basis for personal development (Riessman, 1965; Christmas, 1966; Riessman, 1967; Rappaport, 1977). An oft cited shortcoming in the pertinent literature is the lack of empirical studies that evaluate the effectiveness of the contribution of non-professionals or that measure personal changes occurring within these roles. But as Rappaport (1977) points out, this is not an exclusive problem to this sector given that adequate evaluations in general of service delivery programs are not numerous. Nevertheless, published reports of successful projects involving non-professionals (Rioch, 1967; Poser, 1966; Hallowitz and Riessman, 1966; Durlack, 1973) have added impetus to the movement. The interest generated about the possibilities of indigenous non-professionals or paraprofessionals have also led to an examination of the problems and limitations as attested to by the work of Bartels and Tyler (1975), Toban (1970) and Roman (1973), In terms of training, specifically of indigenous youth from lower-income communities, various reports are encouraging.

Prieto-Bayard (1978) describes a "Peer Interviewing Project" at the Spanish-Speaking Mental Health Research Center in Los Angeles which engaged twelve young students in a survey of drug, alcohol and inhalant abuse in a Hispanic housing project. The research used the peer interviewing model and reported that:

> It provides a unique method of data collection which enhances the reliability and validity of the results. It exposes the interviewers to new experiences and responsibilities and allows them to make a tangible contribution to their own communities (and)...was considered a community and research success.

In some ways Prieto-Bayard's project resembles this study in its focus on indigenous youth and benefit to the community. The training program used likewise is similar in its teaching of particular skills mixed with educational and social experiences. However, whereas the youth in Prieto-Bayard's project had input into the development of the questionnaire, the present study focused on the total participatory engagement of the community youth. Nevertheless, the direction of the Los Angeles project is more similar than others reported. MacLennan (1969) reports on a project involving trainees age 16 to 21 who were school drop-outs, delinquents, or unmarried mothers who were trained to work as "non-professional aides in a variety of human services." Problems which emerged were "coming late, absenteeism, goofing off, lack of know-how in getting help when anything went wrong" or they would be involved in "diversionary argument or even go to sleep or walk out" (p. 138). However, given training and supervision these youths are reported to have developed different attitudes about themselves, their potential and their work. These developments were not however without other difficulties given that the changes themselves created certain distances from their communities, their street milieu, and even the agencies where they worked. MacLennan concludes that:

> Essentially it has to be recognized that the introduction of the indigenous non-professional into an agency puts a demand on all to change not only in terms of the organization of task and job but also through a need to review values and to reach

> out to each other so that good communication can be established...(p. 140).

In a reported model that "might indicate ways of maintaining effective collaboration among former inmates so as to support socially sanctioned behavior in the community," Hawkinshire (1969) discusses vital points of a useful training program. He cites the importance of:

(a) anticipatory role practice for the trainees;

(b) at-the-elbow support of the trainee once he moves into the actual working situation;

(c) feedback to the trainee as to how he is doing;

(d) an effective support group for the trainee to help orient him toward the total situation;

(e) clarity as to the total picture required to function in the job;

(f) realistic case material, role playing, and observation periods of experienced workers;

(g) continuous training.

In a discussion on strategies for training non-professionals, Riessman (1967) similarly lists the points forementioned. He cites the importance of on-the-job training, where skills and concepts form an interactive progression with the very needs of the program. For example, if a meeting had to be organized, the training then involved those skills needed to organize and carry out such a project. As stated by him "As these programs develop, new training appropriate to the program phase can be introduced" in what is called functional learning. Riessman cites the Howard Community Apprentice Program where illiterate research aides progressively learned skills as required. Thus interviewing skills were

learned, then methods of recording information, then ways of categorizing it, and later how to analyze their material. Aside from suggestions already listed by Hawkinshire, Riessman posits the importance of peer learning where the "peer teacher (that is, the more advanced aide) learns enormously from imparting information to the trainee; he learns from teaching." Christmas (1966) likewise discusses training methods with indigenous non-professionals emphasizing the relevance of group training methods, action-oriented approaches and social process. The importance of effective training programs cannot be overemphasized, as Sobey (1970) points out, given that the effectiveness of it will be reflected by the outcome in practice.

Underlying some of these writings, is the awareness of the challenge to professionals that the developing non-professionals present either in role conflicts, possibilities for job advancement or broader participation in the program involved. This challenge, however, is not new to the radical therapy movement which has denounced professionalism and debated the role of skills, therapy and the mental health structure (Glenn, 1973; Henley and Brown, 1973; Cousens, 1973; Tennov, 1973; Galper, 1975). The point is how the so-called "indigenous non-professionals" could participate in a training program which would embrace the major recommendations cited with the explicit concern of simultaneously and interactively developing consciousness of the social reality to be investigated and acquiring skills toward undertaking such a project. In the following section I will describe a method which attempts to address these concerns.

Paulo Freire on method. The pedogogical methodology of Paulo Freire is consonant with the theoretical orientation of this study. However, although Freire's work is much more expansive than can be described here, the author prefers to recognize this limitation, and describe those aspects of Freire's pedagogy which are most relevant to the training process.

Freire's concern is with the development of a pedagogy of oppressed people whereby through their active and participatory engagement in the actions and reflections of their lives, they can develop critical consciousness about their reality thereby initiating an emancipatory process. Such a project necessitates a dialogic encounter in which inquiry and discovery of an oppressive reality are progressively grasped, reflected upon, and problematized. Goulet (1973) expresses this pivotal concept:

> Paulo Freire's central message is that one can know only to the extent that one 'problematizes' the natural, cultural and historical reality in which s/he is immersed...to 'problematize in his sense is to associate an entire populace to the task of codifying total reality into symbols which can generate critical consciousness and empower them to alter their relations with nature and social forces. This reflective group exercise is rescued from narcissism or psychologism only if it thrusts all participants into dialogue with others whose historical 'vocation is to become transforming agents of their social reality. Only thus do people become subjects, instead of objects of their own history' (p. ix).

"Problematizacion," or problem-posing education in Freire's (1973) words "affirms men as beings in the process of becoming--as unfinished, uncompleted beings in and with a likewise unfinished reality" (p. 72). This implies the possibility of perceiving critically the way one exists in the world, in reality, a reality in transformation in which the human

being can be actively engaged historically. "Problematizacion" understood this way posits as fundamental an emancipatory project whereby in the process of inquiry, of this participatory research for humanization, of a dialogical discourse, the process of critical consciousness is potentiated. In order to begin to introduce the critical form of thinking, to interrelate components of a reality within a broader context, Freire calls for an:

> Analysis of a concrete, existential, 'coded' situation. Its 'decoding requires moving from the abstract to the concrete; this requires moving from the part to the whole and then returning to the parts; this in turn requires that the subject recognize himself in the object (the coded concrete existential situation) and recognize the object as a situation in which he finds himself, together with other subjects' (p. 96).

Essentially the coding of situation is a reproduction of it, describing the component elements and their interaction. Decoding is the critical perception of that reality. This process of investigation, which will reveal how the participants view and think about their situation, generates themes about how they view their reality. These generative themes become the focus of exploration and analysis. These "meaningful thematics" are pregnant with the aspirations, motives and objectives of the participants. And Freire expresses that:

> To apprehend these themes and to understand them is to understand both the men who embody them and the reality to which they refer...Thematic investigation thus becomes a common striving towards awareness of reality and towards self-awareness, which makes this investigation a starting point for the educational process or for cultural action of a liberating character (p. 98).

This is a co-investigative process searching for the inter-causation of problems, for the linkages between themes, for comprehending total

reality in its socio-historical and cultural context. In this way, through this praxis, Freire states, can:

> Men emerge from their submersion and acquire the ability to intervene in reality as it is unveiled. Intervention in reality --historical awareness itself--thus represents a step forward from emergence, and results from the conscientizacao[1] of the situation (p. 101).

It is Freire's intent that these processes inform a pedagogy of the oppressed, an educational praxis towards the liberation from an alienating and dehumanizing life situation. Although the scope of Freire's pedagogical orientation cannot be totally feasibly embraced in the training aspect of this investigation, his basic concepts of problematization, codifying and decoding situations, generative thematics, and the co-investigative dialogical method are highly relevant.

The training projects described initially were oblivious to the theoretical underpinning of their methods, consequently they obscured the dialectic of the person-situation. They are approaches which do not explicitly engage in developing critical consciousness or an emancipatory project. They remain in the domain of liberal action and do not question the ideological forces at play, do not challenge the structural reality from which many of the non-professionals emerge. It was imperative to move beyond this limitation and incorporate the essence of a pedagogical methodology which explicitly embarked on questioning an oppressive reality. Given that the population to be investigated belongs to a minority and oppressed group and that the co-investigators,

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[1]Conscientizacao--critical consciousness, "learning to perceive social, political, and economic contradictions, and to take action against oppressive elements of reality" (p. 19).

the trainees were its representatives, this methodology was appropriate.

Insofar as the reality of the trainees and their respective Hispanic community is approached as one to be decoded, as one to be problematized in order to act upon it, to carry out a project as intervention, the study solidarizes with Freire's praxis oriented methodology.

Mental Health and the Puerto Ricans in the United States

Over the last thirty years various studies and articles have been published describing psychological problems among the Puerto Rican people. The overall consensus suggests that Puerto Ricans have high incidence rates of psychiatric problems, often higher than other groups. Though some of the studies have been criticized on the basis of methodology, (Krause and Carr, 1978), ethnocentrism (Rodriquez and Rodriguez, 1975), and misdiagnosis (Rendon, 1974), as a body they point towards the critical need of assessing the mental health needs of Puerto Ricans towards preventive and appropriate services. An overview of this literature is in order.

The literature attesting to the mental health problems which immigration, poverty, limited education, discrimination, and alienation can have on a population or ethnic group is immense. From it emerges one clear notion, and that is that these factors can be predisposing variables to psychiatric problems in a population. Puerto Ricans, as a more recent migrant group to the United States, have been found to be characterized by many of these predisposing variables. In New York City and state, where the largest Puerto Rican population in the United States

resides (one million to one point three million [Burks, 1972]), various epidemiological studies have reported higher rates of psychiatric symptomatology for this ethnic group than for any other ethnic group in the city or for the general population (Rabkin and Struening, 1976). Malzberg (1956) reported, in a study of first admissions to state mental hospitals during 1941-1951, that 1,200 were Puerto Rican, 580 males and 583 females. Of the 1,163 Puerto Ricans that were New York City residents, 58% were diagnosed as schizophrenic whereas for the non Puerto Ricans 31% were diagnosed as such; males made up 62% and females 53.9%. The median age was 24.5 years in contrast to 34.4 years for non Puerto Ricans. Malzberg concludes that "a person of Puerto Rican origin has a greater probability of developing a mental disease during a lifetime than an average member of the entire population" (p. 264). Malzberg (1967) did a similar study including the entire state of New York for 1960-1961 and found that, as measured by hospitalization rates, Puerto Ricans showed an unusually high incidence. Although only 3.8% of the total population at the time, the Puerto Ricans had a 4.5% first admissions and 8.3% for schizophrenia. From this study the black Puerto Ricans, those born in the United States (or second generation) and males were found to be more vulnerable. Noticeably the Puerto Rican late adolescent nearly doubled the rate for non Puerto Rican adolescents and of those admitted 51.9% of the Puerto Ricans versus 27.0% of the non Puerto Ricans were diagnosed schizophrenic. Rendon (1974) in an examination of these hospitalization rates as reported by Malzberg, focused on the impact of transculturation as an added stressor to the lives of Puerto Rican

adolescents. He discusses the possibility of dissociative phenomenon being misdiagnosed as schizophrenia and calls for the need of differential diagnosis. Rendon states that:

> It is my final hypothesis in this paper that the incidence of schizophrenia among Puerto Ricans appears high partly because of the lack of understanding of cultural phenomena. I submit, and this remains to be tested, that many hysterical dissociative episodes, especially in adolescent Puerto Ricans have been diagnosed as schizophrenia (p. 21).

In 1968 the work of Malzberg was replicated (Fitzpatrick, 1971) and the findings indicated that the rate of first admissions for schizophrenia in 1967 for Puerto Rican males in New York was 122 per 100,000 and for females 84.2. This contrasted to the general population's rate of 36.6 for males and 32.6 for females. However, Fitzpatrick, like Rendon, cautions against the possibility of misdirected diagnosis which may explain previous findings of prevalence of schizophrenia among Puerto Ricans.

Various community surveys have attempted to assess the mental health of Puerto Ricans in the United States, particularly in New York City. In Srole, et al.'s (1962) famous Midtown Manhattan Study, half of the 27 Puerto Ricans were diagnosed as impaired (44%) with marked (18.5%) or severe (25.9%) symptoms. This rate was double that of any other group in the study. In this sample Puerto Ricans had the highest number of symptoms measured in psychophysiological terms. Dohrenwend and Dohrenwend (1969) in a sample study of the Washington Heights area in New York City, found that Puerto Ricans reported more psychiatric symptoms on the 22-item screening instrument used in the Midtown Manhattan Study than for the other ethnic groups studied. These authors cautioned

that methodological considerations such as cultural differences in response styles, ways of expressing psychological distress and notions of socially desirable behavior may be factors inflating the obtained findings. Haberman (1970) similarly found that Puerto Ricans reported more symptoms than other ethnic groups in a household survey. Haberman (1976) in a cross-survey analysis of the patterns of responses to questions about psychiatric symptoms from surveys conducted in New York City and in Puerto Rico concluded that:

> ...culturally patterned differences in modes of expressing distress (are) the most parsimonious explanation for their high rates of the specific symptomatology examined (p. 144).

The above authors are aware of the effects which cultural differences and stressful reactions to migration may have on their findings and consequent interpretations. Dohrenwend (1966) argues, however, that the high symptomatology scores obtained by Puerto Ricans may indicate high levels of anomie and not mental disorder. He stated that:

> ...the responses of lower class Negroes and Puerto Ricans... are less evident of personality disorder than of what Durkheim has described as 'derivatives' of anomie...

Anomie is defined by Dohrenwend (1959) as "weariness, disillusionment, disturbance, irritated disgust with life, and exasperated weariness." Concern with this issue and with methodological limitations of the survey assessment of the mental health of Puerto Rican migrants were studied by Krause and Carr (1978). They focused on the effects of response bias and concluded that:

> ...no significant relationship between psychiatric symptomatology and the migratory status of our Puerto Rican sample. The results suggest that, when acquiescence to health-related

> items is controlled, any significant relationship between age, sex, migratory status, education and symptomatology disappears. In addition,...anomie scores among Puerto Ricans had no bearing on their symptomatology scores.

These authors call for controls for response set bias in survey instruments and also question the theoretical explanations of the migration-mental illness relationship.

Other studies not based on the survey instruments already discussed provide further data on the mental health of Puerto Ricans. In a study of attempted suicides in New York City, Trautman (1961) states that "A high rate of admissions of Puerto Rican suicide cases prevails in all city hospitals serving this population" (p. 544). He notes that, of 131 suicide-attempt cases, 71% were Puerto Rican immigrants. In a more recent study of three ethnic groups (Puerto Ricans, Blacks and whites), Monk and Warshauer (1974) found that "Puerto Rican men had the highest rates of completed suicide of all groups and Puerto Ricans, both men and women, attempted suicide two to three times more often than either Blacks or whites." In a study of the relationship between acculturation and psychopathology in a sample (N = 72) of Puerto Rican women resident in the United States, Torres-Matrullo (1974) found that the level of acculturation significantly related to personality adjustment and psychopathology. This investigator found that those women "low" on acculturation obtained scores on the Wittenborn scales on Depression and Obsessive-Compulsion which were higher than those women high on acculturation. What was a surprise was the low incidence of schizophrenia in this sample, a finding contrary to many previous ones about Puerto Ricans but which also supports further questioning of possible misdiagnosis.

In more recent data from New York City sponsored by the Hispanic Research Center (Alers, 1978) the author states that:

> The rate of admission for Puerto Ricans is higher than for either of the two racial/ethnic groups considered (whites and blacks). These refer to mental retardation; psycho-physiologic (including respiratory) disorders; special symptoms (such as speech disturbance); transient situational disturbances (adjustment reactions throughout the life cycle); behavior disorders of childhood and adolescence; and various kinds of social maladjustment without manifest psychiatric disorder (p. 16).

This study noted that schizophrenia, while not as high as in the Black population, is still the highest category for the Puerto Ricans. Although this "devastating picture" is described, the author again cautions against the existence of biases within the data due to possible questionable diagnosis by non Puerto Rican staff. In this study's overview of drug abuse among Hispanics during the period of 1971 to 1974 as first reported to the Narcotics Register, Puerto Ricans second to Blacks are found to have rates of addiction higher than those of the white population. In general, however, drug addiction among Hispanics has been found to be three times as frequent cause for psychiatric hospitalization than for Blacks and Anglos (Bachrach, 1975). The situation for alcoholism, although not as vast a problem, is still serious. In Bachrach's study of psychiatric admissions to state and county hospitals alcoholism among Hispanics was rated as the third cause of their admission. Indicators of the scope of problem drinking among Hispanics cite high rates of alcoholism in Hispanic communities as suggestive of the stress of acculturation (Hall, Chaiken, and Piland, 1977). Although statistical data are scarce as to the extent of an alcoholism problem among Puerto Ricans, the overall impression is that the problem exists,

is numerous but hidden by the cultural mores of this very community which tolerates and denies it (Abad and Suarez, 1974; Davila, 1979).

From a different perspective to these studies, is the data available from the clinical situation. Abad and Boyce (1979) describe the symptomatology of 238 Puerto Rican patients and analyze the critical issues in the evaluation and treatment of this population. In this sample, which compared whites, Blacks, and Puerto Ricans, the authors report that:

> Puerto Rican patients demonstrated a higher frequency of sleep-in and eating problems, physical problems and somatic concerns, suicidal thoughts and gestures, disturbances in parent-child relationships, hallucinations, seizures, assaultive acts, anti-social behavior, inadequate intellectual development, and dis-orientation (p. 29).

These authors note that the main components among Puerto Ricans are depression, anxiety, somatic concerns, hallucinations, and actual or feared loss of control. They comment that Puerto Ricans tend not to report depression as such, but present symptoms of insomnia, fatigue, headaches, body aches and feelings of weakness and exhaustion. Likewise, anxiety is not recognized as such by the Puerto Rican patients although the symptom picture makes this evident. The most "pervasive single theme reported" by these patients was that of actual or feared loss of impulse control. These fears can be expressed in many ways: directly or through symptoms. Alcohol is reported as increasing the vulnerability to loss of control. The difficulty of dealing with hostile feelings, suppression of anger, and consequent maladaptive ways of expressing anger have been discussed by Rothenberg (1964). An example of such loss of control is the "ataque" or "ataque de nervios"

called the Puerto Rican Syndrome in English, which has been discussed by various writers (Mehlman, 1961; Fernandez-Marina, 1961; Rothenberg, 1964; Garrison, 1977). The importance of Abad and Boyce's work is its base on clinical material, and their emphasis on looking at the impact of socio-economic and cultural factors toward improving service delivery.

The overall picture is not encouraging even though many areas require critical research in order to appropriately assess the mental health of Puerto Ricans in the United States. It is crucial however to remember that most studies of the mental health of migrant groups report higher rates for these conditions than for non-migrants (Bagley, 1968; Murphy, 1965; Sanua, 1969; Rabkin and Struening, 1976). Also we must add to these the literature of the relation of mental health and lower socio-economic groups (Hollingshead and Redlich, 1958; Brenner, 1969, 1973). On the other hand, we cannot ignore the data as we come to grips with the consequences of migration, poverty, limited-education, unemployment, alienation, childrearing patterns, in essence the socio-economic, cultural and historical context of the experience of Puerto Rican people in the United States.

Given this picture, could we expect that the Puerto Rican people seek out established mental health services? Could we expect that relevant services to this population be organized and well developed? Could we expect that more Hispanic mental health workers be found in the field? Unfortunately, even though it would seem that these questions should be answered affirmatively, they cannot be. Lubchansky,

Egri and Stokes (1970) state that "Puerto Ricans appear less likely than other groups in the population to perceive a need for treatment by mental health professionals." These authors have found that the tendency is to consult a Puerto Rican spiritualist, or as they say "an indigenous non-professional in the field of healing." However, Elinson, Padilla, and Perkins (1967) found that less than 9% of their sample of Puerto Ricans in New York City stated that they visit the "espiritista." However, the focus on culturally relevant mental health services (Gaviria and Wintrob, 1979; Lubchansky, Egri and Stokes, 1970; Rogler and Hollingshead, 1961; Delgado, 1977; Padilla, Ruiz and Alvarez, 1975; Badillo Ghali, 1977) which has developed over the past decade partially in response to the under-utilization and irrelevancy of available services (Cohen, 1972; Abad, Ramos and Boyce, 1974; Padilla, Ruiz and Alvarez, 1975) has given legitimacy to the "espiritista." While this movement reflected a legitimate concern, the dangers of obscuring the contextual sources contributing to mental health problems have increased (De La Cancela, 1979; Zavala, 1979). Similar to the poor use that Puerto Ricans make of established mental health services, is the irrelevancy and lack of appropriate services to this population and Hispanics in general (Zavala, 1980; Padilla, Ruiz, and Alvarez, 1975; Abad, Ramos and Boyce, 1974; Torrey, 1972). Hispanics have tended not to use the available services and these in turn have been described as irrelevant and culturally insensitive. The relation may be clear. Finally, our question as to the number of Hispanic mental health workers must be answered tentatively. According to reviews of the representation of

Hispanic students and faculty and minorities in general in psychology, the numbers are glaringly few (Boxley and Wagner, 1971; Olmedo and Lopez, 1977; Suber, 1977). Although more Hispanics may be entering the mental health fields, the need is even greater.

In summary, this final section has attempted to report on the available literature of the mental health of the Puerto Ricans in the United States, on some of the related socio-economic and cultural factors, and on the use and availability of services. This overview is a necessary backdrop in which to understand the salient results of this study.

C H A P T E R I I I

METHOD AND PROCEDURES

Introduction

The participatory research method is a dialogical, action-oriented, non-hierarchical investigative process grounded in the praxical understanding that through the actions, interactions, and activities with other human beings and with the world, persons constitute themselves, develop, and transform themselves and the material world. The ramifications of praxis as a theory of action and as a basis of knowledge informs the participatory research method and vitalizes its possibilities as a militant methodology. The concern has been the need to develop and articulate a methodology which embodied possibilities of an emancipatory project. This method is appropriate to the research approach of this study as it corresponds with the author's intent and orientation, engages the concepts of action-research (Lewin, 1948; and Sanford, 1970), but goes beyond their functional limitations towards the compelling potential of a liberating praxis.

It is the purpose of this chapter to describe the development of the participatory method in its basic phases with a concise delineation of the research procedures undertaken. Given that this study is explorative in its approach to methodology, it suggests the basic groundwork for participatory research, details its possible format, describes findings within these considerations, and enumerates recommendations

for future projects. Whether indeed this methodology has emancipatory potential and generates actions that are liberating can be gauged by the degree that the participating youth appropriate consciousness of their concrete reality and by the involvement of the participating community in determining its needs and in taking steps towards transforming their social reality.

The Participating Researchers and Hispanic Youth

Ten Hispanic youth were chosen by the sponsoring agency from a pool of youth applying for summer employment and interested in working with their community. The youths were selected based on these criteria: 14 to 21 years of age, residents of the Hispanic community, eligible according to CETA income guidelines, and a balance between females and males. No particular screening tests were given. The staff selecting the youth were themselves Hispanic community members.

These participatory researchers consisted of 4 males and 6 females. The group's mean age was 17.4 years and the mean educational attainment was 11.8 grades. Five of the youth were still in high school, one was an unemployed high school graduate, one had recently finished high school and three were undergraduate college students. Five of the youths lived in the communities to be researched and five lived in nearby towns. None had ever participated in a research project before and did not know what needs assessments were. The language of daily use was generally Spanish, although English was resorted to by 3 youths who had been raised in the United States. The language issue created some conflicts which will be explained

further. All youth, however, understood and spoke English fairly well. The investigator's impression was that their socio-economic level was of lower working class background. The youths had all come to the United States with their parents, some who migrated over 15 years ago. Nine of the youths were Puerto Rican, one was Colombian. Four had been raised most of their lives in the United States, six had lived on the mainland for the past four years or more.

The Participating Community Subjects

The sample was randomly chosen from a mailing list of Hispanic members of the community comprising three public housing projects (N = 50) and three town centers (N = 15). The total number of persons interviewed was 65 in these areas. The Hispanic community under study was originally established as an outgrowth of the migrant Puerto Rican farm workers as early as the late 40's and early 50's and grew as families came to join their male wage earners or other kin. In the early 60's the Hispanic community was enlarged by families resettling from New York, New Jersey, Chicago, Hartford, and other large urban centers. Most of the families wanted a quieter place to live and raise their families. This was found to be the case in the data of this investigation.

Initially the Puerto Rican farmworkers came to work in the tobacco and apple farms in the areas near Northampton, namely Westfield and Hatfield. As new migrants came, others moved on to work in textile and other factories in Holyoke and Springfield. The shortage of housing

in these areas forced some families to move to the Northampton area. The Hispanic families are mainly found in three public housing facilities: Florence Heights, Hampton Gardens, and Hampshire Heights. Florence Heights is the oldest of the housing facilities. It was constructed after World War II with federal funds as low income housing. Presently it is administered by the Northampton Housing Authority. Florence Heights is an isolated community in that it is distant from the main town centers, has no public transportation, the apartments are in poor condition, and limited recreational facilities exist. It is a physically depressing facility where living conditions exacerbate the frustrations of poverty and isolation. Ironically, this housing project is beyond the industrial center of Northampton, where various big factories exist which once were a source of employment for the community. Hampton Gardens is a new housing project built in the 60's. Different from Florence Heights, it is a project with residents of mixed incomes. It is larger, better developed, and environmentally more agreeable to community life. Playgrounds, laundromats, and other facilities are present or are more easily accessible than for the residents of Florence Heights. Hampshire Heights is also administered by the Northampton Housing Authority and is proximate to Hampton Gardens. Originally it was built some years after Florence Heights for veterans. It too is a more desirable housing facility than is Florence Heights, though only about four Hispanic families live here. Another housing facility, Meadowbrook, is distinct in that it is a completely private facility with very few low income families. This housing center has

numerous facilities including a pool, a community center, and a playground. Only two or three Hispanic families live here. For the purposes of our study, we will identify Florence Heights as one distinct residential center and group Hampshire Heights and Meadowbrook with the Hampton Gardens residential sector.

The community's contact with the research endeavor occurred in different ways. First, the community, as an integral aspect of the training process and research goals, was invited to a community meeting to discuss the needs and problems of the community. As will be described, the community generated at this meeting the problem areas which were then structured into the survey instrument. Second, an article appeared in the community paper and third, a letter (see Appendix A) explaining the project further was sent to the Hispanic community members.

Praxis, Training and the Survey Instrument

The process of developing the survey instrument in itself constitutes the basis for a dialogical participatory praxis oriented methodology. The crux of this interaction occurred in the day-to-day training workshops which not only progressively generated the method, but derived from its actual process the elements and impetus for further development. Given their crucial importance, a summary of the overall format and a description of the weekly workshops are necessary.

Goal of the workshops. The specific purposes of the workshops were to prepare the youth towards the development of a research instrument and its use in the community, and to note any indices of development or growth of social and personal awareness. To these ends, the youth had to learn what needs assessments were, how community needs and problems get identified, how a survey questionnaire is constructed, how to interview, how to gather the data, and finally how to code the obtained material in preparation for data analysis.

Consistent with the pedagogical methodology described earlier, the workshops intended to pose problem situations which were perceived in certain ways by the youth. The situations, according to the workshop theme were then decoded; that is, they were examined and questioned and linked to their socio-historical and cultural context. This process forms the basis for the development of the survey instrument as it embodies the growing consciousness of the youth of the social reality of their community and articulates it in an organized format to be taken back to the community.

The workshops. The amount of time given for the entire project as dictated by the sponsoring agency was eight weeks. The youth participated in the project 4 days a week from 9:00 a.m. to 4:00 p.m., and the fifth day was spent with the funding agency. For the purpose of this study, description of weekly workshops means 4 days. The first 3 weeks involved preparing the survey instrument; the fourth week involved a pilot practice and revisions; weeks 5, 6, and 7 were taken up by field work and actual data collection, and week 8 was for coding, evaluation and ter-

mination of the project.

Week I. The first 4 days of the project were the groundwork for the rest of the training period. Once the initial introductions were made to the trainers, to each other and to the project's goal, participants shared experiences about their community lives which led into a discussion focusing on the Puerto Ricans and their community lives as perceived and understood by the participants. From day 1 the group collectively entered into a dialogue of questioning and examining the community situation of the Puerto Ricans. The questions asked were:

1) What are the characteristics of the Puerto Rican people that we all commonly know?

2) What are the characteristics of a community? How is a community formed? Based on what?

3 What problems exist in our community? What needs do people have? How do you know this?

These questions became the themes to describe situations (codifications) which then were decoded in collective process of discussion, given the level of the participants and the time allotted for each process. General lists were written up on the blackboard to answer these questions in an open group discussion. The lists of responses were then recorded by the group's elected recorder to be later analyzed in more detail. The first day ended with a brief tour of the housing areas which comprise the Hispanic community. The co-investigators were asked to write down their impression in a daily log and ten minutes were structured at

the end of each day for this reflective activity.

Day two began with concrete historical and social information about the housing areas seen the day before and about general statistics on the Hispanics in the United States. Given that on the day before lists of problems and needs of Hispanics were generated in an open discussion, the morning workshop focused on explaining the purpose and methods of assessing needs in a community. Sample needs assessments were distributed for the youths to examine. Then sample needs assessments made within the geographical area in consideration were discussed and passed around (Health Needs Survey, Amherst Board of Health; A Survey of Needs Assessments in the Franklin-Hampshire Area). It was noted that the Hispanic community's mental health needs had not been surveyed and that no community forums were included in the methods used. The project's goal was not only to identify mental health needs but also a range of social service needs with the fullest participation of the community. The preferred assessment method was a questionnaire that would identify the needs and problems of the Hispanic community. A task was assigned in the afternoon to begin to deal with constructing the questionnaire:

> According to the characteristics of the Hispanic community that were listed yesterday and today, how can we identify their needs? Try to describe how a questionnaire might look according to the problem areas described.

Three groups were formed and needed materials such as paper, pencils, sample assessments, copies of the lists generated previously were given out to each group. Each group met for forty-five minutes and regrouped to share and discuss their suggestions. The amount of information generated in each group was surprising. Each group engaged in the task

very industriously. Collectively the group then discussed each other's work and final suggestions were written up on the board. The following areas were to make up the survey:

Group I--General Information, Economic Situation, Education;

Group II--Transportation, Health and Mental Health;

and

Group III--Family Matters, Community Organizing, Justice.

Each group was assigned 3 areas and had already begun listing questions that would be pertinent to each section, and these were reviewed and either consolidated with other questions, eliminated, or identified under a category. The co-investigators indeed were generating the basic components of the survey instrument based on their dialogue and examining of the basic problem areas listed previously. It was impressive to observe the collective capacity of these youths. But one question was posed: What about the community, did we not want to involve them in the process? Were they to again be recipients of others' actions instead of active participants and decision-makers?

Day 3 was devoted to discussing and organizing a community meeting. Again, the situations to be decoded were posed as problems: Why involve the community? What purpose would this meeting have? What does the meeting have to do with the survey instrument? How do you hold a community meeting anyway? What needs to be done? How do we organize it?

Each of these questions posed a problems to be examined, presented a situation to be described and then analyzed and called for concrete

answers. Each question was answered through dialogue and debate and the final outcome written on the board. At the end of the morning's discussion it was clear that via the planned meeting the project would attempt to engage the community in identifying its own needs and problems so that these would be incorporated into the survey instrument. It was also clear that a series of tasks needed to be done ranging from publicity to concerns about childcare during the meeting. In the afternoon all tasks were identified and committees formed to come up with plans for accomplishing these tasks. Four committees were organized: publicity, agenda, childcare, and transportation. Collectively, the group decided the date, time and place of the meeting.

Day four, and the last day of the first week was a very task oriented day. The group met collectively for a half-hour to review their committee assignments and then held individual committee meetings for the next hour and drafted specific plans and ideas which were then decided upon when the group reconvened in the late morning. Once each committee reported and all necessary decisions were made and discussions held, the planning for the community meeting was well underway. The afternoon was devoted to preparing any materials needed and as such a flyer was made and distributed to the community, telephone calls for transportation, children's films, refreshments, etc. were arranged. The agenda committee, whose task was to brainstorm on how to organize the meeting itself, what to say, and how to say it, produced an impressive introduction and format for stimulating participation in the meeting.

Week 2. The beginning of the second week, day 5 was another very task oriented day. The final details of the meeting needed to be reviewed and a series of small tasks had to be finished. The agenda committee read its plan and it was suggested that once the necessary introductions were done, that those community members present would break up into smaller groups to draft a list of needs and problems that they felt the Hispanic community had. Each group would elect a member to read this list to the others when they regrouped for a final discussion. The youth felt that this method would ensure more individual participation and would more actively engage the community in the overall assessment project.

Notwithstanding the impressive planning for the meeting and the high enthusiasm of the youth in being involved in such an activity, relatively few community members attended the meeting. A total number of 12 persons attended, 8 women and 4 men. Although this attendance was much less than the 30 to 40 expected, the meeting did generate a list of needs and problems and the project was seen as necessary by those attending. These comments were the general focus of Day 6. The youths discussed the possible reasons for the lack of attendance and analyzed why these might be. The general mood was one of disappointment, given the amount of planning and energy that went into planning for the meeting. We examined these feelings, attempting to put them in perspective given previous discussion of how people seemed to have gotten used to not participating, to not having any power over their lives. The group then discussed how they have felt when they were in situations

where they felt they could not control what was occurring to them and what ways they developed to deal with these feelings, and how some of these ways might resemble experiences the Hispanic community in general has had. This reflection based on examining the components of the feelings experienced was an attempt to not "blame the victim" (Ryan, 1972) and to gain understanding into a difficult area within community dynamics.

The afternoon of Day 6 involved reviewing the list of needs and problems generated by the community meeting and determining to what categories they belonged. Again, the group was divided into the same 3 groups which worked on generating the initial survey areas. This time the goal was to prepare appropriate questions under each section (each group had 3 categories) that could be included in the questionnaire. Prior to the small group task, we emphasized the need for simple, clear and precise use of language. We also discussed phrasing questions, using terms and words known and understood by the Hispanic community.

Days 7 and 8 continued the process of generating questions and possible answers to select from under each category and validating with the larger group. In addition to the actual survey construction, interviewing techniques were learned and practiced. The procedure for learning these followed the problem posing approach used throughout the training. The problem of how to carry out an interview and what was needed to do this was discussed collectively. All suggestions were written on the blackboard and then the main points were further examined. Situations identified as crucial were: introducing oneself at the door, explaining the purpose of the interview,

learning to listen with ears, eyes and body (attending), being able to clarify any question, feeling comfortable and at ease in what one was doing. These situations were expressed as necessary for successful interviewing. To check this, each situation was role-played using a variety of different and difficult attitudes, whether of the interviewer or the interviewee. From this role-playing sequence certain rules were generated: no gum-chewing during the interview, no smoking, no fidgeting with objects.

Week 3. As a continuation of the initial interviewing skills development, a written introduction was drafted which explained the project and which was to be practiced in teams of two. As a rough draft of the questionnaire was ready, it was decided that the practice should involve not only the introduction, but that in order to become familiar with the questionnaire the co-investigators should tape their team practice sessions. Much embarrassed laughter could be heard during the initial half-hour of the practice sessions, but gradually this was transformed to a more serious endeavor. The rest of the week involved reviewing parts of the questionnaire which were ambiguous or too long coupled with interviewing practices. This week was tedious in that certain parts were reviewed and rephrased. A restlessness was beginning to set in as the youths were eager to get out to the community and do the interviews as soon as possible. Given this situation and given that the mental health portion was not completed, the trainer took the responsibility of writing up the items that were to form the mental health section. First, however, a collective dis-

cussion was held. The group identified mental health problems that had been identified at the community meeting and these were listed on the blackboard. The trainer-facilitator then asked how we were going to find out about these problems. Three ways were concluded from the ensuing discussion: 1) the questionnaire would have questions asking whether the identified problems existed in the community and to what degree by the use of a frequency scale; 2) questions would be similarly asked about the identified problem areas existing in the family; and 3) the interviewee would be specifically asked if they had experienced a list of problems in the past year. Also it was decided that it was important to know to whom the community went when they had emotional difficulties, so three questions were generated to tap this information. Questions on whether any mental health service was used in the past year and if any medication was being taken were also included. The basic considerations were recorded so that the trainer-facilitator could then specify the item questions. Initially, information was sought on surveys of mental health needs done in the area and although some are identified in the "Survey of Needs Assessments in the Franklin/Hampshire Area" by Michael Glish and George Brennan (November, 1977), when these were requested, they could not be obtained. Further inquiry revealed that not even the Department of Mental Health's Northampton office could trace a sample questionnaire on the specific area of mental health. What was available were Langner's 22-Item Mental Health Index (Langner, 1962) and Gurin Mental Status Index (Gurin, et al., 1960). It was clear that given the exploratory nature of the community

survey, these known measures could serve as a guide to the preparation of the project's own index, but to consider exact replication was beyond the scope of the project. However, using these measures as a guide, thirteen questions were drafted which inquired into emotional problem areas in a language that was oriented to the community, in a vernacular which was non-threatening and which could minimize response bias. The problem of social desirability bias was not controlled for specifically in the scale which the project generated, and the findings must be viewed with this limitation in mind. At most, the 13-item scale can be further refined to approximate a more valid measure of a community's self-reported mental health. For the purpose of the project, it was a useful indicator of approximate mental health. This approximation can also be supported given the questions raised in the literature as to the methodological problems of both Langner's and Gurin's scales (Seiler, 1973; Schwartz, Myers and Astrachan, 1973; Krause and Carr, 1978).

The third week concluded with a collectively approved draft of the mental health section as well as a nearly completed survey instrument.

Week 4. As the questionnaire draft was ready for a pilot practice, the first day of the week was spent reviewing interviewing skills, the introduction to be given at the door, and organizing who was going where and with whom. Five families were randomly selected and telephoned about being interviewed the next day. All five agreed and a time schedule was made. The group of ten youths were divided into five

teams of two each, balancing for language, sex, age, and place of residency. For example, those whose Spanish was not good were teamed up with a partner with complete fluency; the younger members were paired with older ones; and those that lived in one of the communities were sent elsewhere. Towards the end of the day plans for the pilot practice were completed and the purpose of the practice was discussed as another way of validating the usefulness, thoroughness, and applicability of the instrument.

The pilot practice was carried out as planned. The youths were very excited to be doing such a service, to be feeling important (see daily log excerpts in the final chapter) and were noticeably rowdier. The day after the pilot practice, the experiences of the day before were recounted and a list of concerns and difficulties emerged. Each team had been assigned to designate one member as interviewer and the other as recorder of any questions, reactions, or problems that arose during that particular interview. When we began to pull these team notes together, similar questions and problems arose. Among the main concerns were: the length of some questions and answers to choose from, the ambiguity of some items, the repetitiveness of others, the uncertainty whether people really gave true answers particularly in regards to income. It was confirmed that people responded best to structured questions (minimizing the "I don't knows"), and that a brief explanatory introduction to each section was well received. Problems encountered in the home of the interviewee were generally related to the frequency of interruptions because of children, the telephone or some

other household matter. Ways of dealing with these situations were suggested and it was decided that the team member not actually interviewing should be instrumental in minimizing the interruptions with his or her direct action. This meant that a baby might be quieted or some other help done so that the interview could proceed.

In order to correct the problems in the questionnaire structure itself, the small groups met in the afternoon with assigned sections to improve. Later the small group suggestions were discussed by all and final changes recorded. On the last day of the week there was a workshop on sampling procedures and data collection. This workshop gave the investigators a firmer sense of the research they were actively involved with. They were aware that they would be interviewing in the community but the phraseology of "sampling" and "data collection" held an academic tone that was curious and interesting to them. The sampling procedures most appropriate and given the limited time relied on a mailing list of the families in the Hispanic community. Each address and telephone number was given a code number which corresponded to a questionnaire. This master list was kept by the agency supervisor until the data collection process was finished, then it was destroyed. Distinct areas of residency were given the same numerical ranges, for example X housing project would be 100-199 whereas Y housing project would be 200-299. One hundred families were identified to be interviewed although only 80 were interviewed, 65 of which formed the basis for the data analysis. The other 15 were excluded becuase they were members of a distinctly different geographic and social community. Of

the 20 that were not interviewed, 11 of the identified did not wish to participate in the project, and 9 were either never located at home or had moved from the area.

These procedures were discussed in group and the afternoon was action oriented as many tasks related to these sampling procedures had to be accomplished. Arrangements for interviewing had various components. The community knew of the project through letters sent and through the community newspaper. One of these communications explained that the person would be called and asked if they could be visited and when. In this way all interviews were pre-arranged by phone and schedules for the weeks of data collection could be prepared a week in advance. This did not entirely prevent certain problems in gathering the data, but it did help structure and organize the process. The actual interviewing procedure consisted of five teams of two youths per team, with one team assigned to administrative tasks for the project on a rotative basis. At the home of the interviewee one youth was attendant to record when the interview began and when it ended, to make observations as needed, and otherwise facilitate the process of interviewing in the home. Based on this format, three weeks (weeks 5, 6, 7) were taken up with collecting the data; in other words, interviewing in the community. Each field work day began with a group meeting in which the day's tasks were assigned, transportation arrangements made, and any leftover problems and questions from the previous day's experience were discussed. In this way, each day was built on the previous one, and as the youth gained experience and self-confidence six of them

were allowed, after one and half weeks of field work, to interview by themselves. The three weeks of data collection were intense, sometimes frustrating, sometimes exciting learning experiences for the co-investigators.

Week 8. The last week was tightly cramped with activities. The first two days were spent in a workshop on scoring and coding. It was clear that the youths would not have the opportunity to be involved in this process, but it was crucial that they understand what happened next to all the questionnaires that had been filled out and what steps came in between these and the final numerical results. A consultant to the project conducted the workshop on coding and data processing. As part of a practice exercise, the youths learned how to transfer the questionnaire responses onto the IBM OPSCAN scoring sheets. The answer key had been previously prepared by the trainer-facilitator.

The next to the last day of the project involved an evaluation of the whole project. It was necessary to first decode the theme: evaluation. What did this mean? How does one evaluate? Based on what? How do you measure what you want to evaluate? Again we examined the significant components of what an evaluation might be and these were written up on the board. The group generated ways to evaluate themselves individually, the group collectively, and the outcome of their investigative efforts. It was decided that a questionnaire would be prepared with a series of questions in Spanish which were to be answered individually (see Appendix B). The questions that were to make up the individual evaluation were discussed and their main ideas written

on the blackboard for the facilitator to take and organize. In order to evaluate the group collectively, a group exercise was decided upon which would consist of answering in group discussion basic questions on group process, relationships, problems, and suggestions for future projects. This was to be taped and then played back for all to hear. As another way of assessing the individual and collective experience of the project, the facilitator was permitted to collect the daily logs and review them. The qualitative nature of these does not lend themselves to a thorough analysis, but their valuable insights merit anonymous reproduction. In the final chapter quotes from these daily logs are cited particularly those that provide or suggest evidence of a development of growth of consciousness about the social reality the youths experienced and about themselves.

The third dimension of the evaluation relates directly to the results of the obtained data which will be discussed in the next chapter.

Data Analysis

The handling of the data proceeded through the following steps:

1) the responses were recorded directly on the instrument;

2) coded responses were transferred to the OPSCAN sheets;

3) the OPSCAN sheets were processed at the Data Processing Center and a magnetic tape containing all data was made;

4) the data were processed using the Statistical Package for the Social Sciences (SPSS). Sub-programs used were: Frequencies and

Crosstabs.

The data analysis used the main statistical methods of mean and chi-square. The level of significance was established at .05.

The data will be presented in the Results chapter as simple tabular description of the demographic characteristics of the population sampled along with summary paragraphs. Cross-tabular presentation on the mental health problems and identified needs will be presented, looking at the relationship between these and demographic variables such as sex, age, education, marital status, education, and yearly income. The result section will also look closer at identified stress indicators existing in the community.

C H A P T E R I V

RESULTS

Introduction

The findings of the survey instrument will be discussed in three sections:

1) Profile of the Community Respondents;

2) Mental Health Profile;

3) Identified Needs and Human Service Use and Preferences.

Although the survey instrument covered other areas, for the purposes of this study any findings from these areas will be mentioned only as they relate to the primary concern of identifying mental health needs and problems (see Appendix C).

Profile of the Community Respondents

The respondents' demographic characteristics are represented by Table 1. The total number of respondents in the survey was 65. Female respondents accounted for 73.8% of those interviewed. The mean age of the respondents was 34 years, although 44.6% were under 29 years and 20% were 45 years and older. Most respondents interviewed were married, whether formally or consensually (56.9%). Of those who were single (41.5%, or 27 respondents), 17 can be also identified as single heads of households as they have children, 6 identifying themselves as divorced and 7 as widows. The mean number of children reported was 2.12. Thirteen respondents (20%) reported no children, 25 households

TABLE 1

Demographic Profile of the Hispanic Community Respondents

Characteristic	Total Sample (N)	Percentage of Sample	Mean	Mode
Sex				
Female	48	73.8		
Male	17	26.2		
Age Group (Years)				
29 and under	29	44.6		
30 to 44	22	33.8	34.1	27.0
45 and older	13	20.0		
Marital Status				
Married formally or consensually	37	56.9		Married
Single with or without children	27	41.5		
Place of Birth				
Puerto Rico	54	83.1		Puerto Rico
Elsewhere	11	16.9		
Years Living in Hampshire County				
3 or less	30	46.2		Less Than One Year
4 to 9	20	30.8	6-8 years	
10 or more	15	23.1		
Years Living in U.S.				
3 or less	13	20.0		
4 to 9	10	15.4	14 years	14 years
10 or more	42	65.4		
Education				
None to 11th grade	42	64.6	9-11th	9-11th
High School and more	23	35.4		

TABLE 1 (CONTINUED)

Characteristic	Total Sample (N)	Percentage of Sample	Mean	Mode
Source of Income				
Salary	32	49.2		
Social Benefits	33	50.8		
Yearly Income				
Less than $6,084	25	38.5		
$6,084 to $10,080	29	44.6	$7,270	$3,600
Over $10,081	9	13.8		
Number of Children				
None	13	20.0		
1 or 2	25	38.5	2.12	2.0
3 or more	27	41.5		
Language Spoken At Home				
Only Spanish	32	49.2		
Mostly Spanish, a little English	7	10.8		
Half Spanish, half English	20	30.8		Spanish
Mostly English	2	3.1		
Only English	4	6.2		

(38.5%) reported either 1 or 2 children, and 27 families (41.5%) reported 3 or more. The majority of the community respondents were born in Puerto Rico (83.1%). The length of residence in Hampshire County varied from 46.2% having lived 3 years or less in the area, to 30.8% having lived 4 to 9 years, and 23.1% stating they have lived in the county 10 years or more.

The mean educational level of the respondents was from the 9th to the 11th grade with a standard deviation of 2.2. Forty-two respondents (64.6%) fell in the range from no education to the 11th grade, whereas 23 respondents (35.4%) had finished high school. A cross tabulation of sex by education was found to be significant ($p < .0397$) with a chi-square value of 4.23 and 1 degree of freedom in the direction of females. The Puerto Rican women had significantly less education than the men.

The main sources of income for this community were derived from salaries (49.2%) and varying social benefits (50.8%). The breakdown of those receiving social benefits was that welfare recipients formed 33.8% of this group, social security recipients formed 12.3%, unemployment recipients constituted 3.1%, and 1.5% received child benefits. A total of 30 persons received food stamps (47%). The total yearly income for this sample had a mode of $3,600 and a mean of $7,270. Grouped into 3 levels, 38.5% had less than $6,084; 44.6% made between $6,084 and $10,080 and only 13.8% made over $10,080. A cross tabulation between the source of income and yearly income reveals a significant ($p < .001$) interaction. Those persons with a yearly income of less than $6,084 received social benefits whereas those with a yearly income of over $10,000 received salaries. A cross tabulation between yearly income and economic situation

as described by respondents shows a significant relationship at the .0378 level. Those whose incomes fall below $6,084 describe their economic situation as "bad" and not one person describes it as "good." In the middle income bracket group, 51.7% describe their economic situation as fair and 31.0% describe it as bad. In the over $10,000 group 66.7% describe their situation as fair and 22.2% say its bad.

The length of residency in the county versus that of the United States is noteworthy. Whereas 46.2% of the respondents had lived three years or less in the county and 23.1% had lived over 10 years, 20% had lived three years or less in the United States and 65.4% had lived over 10 years in this country. The language spoken at home does not necessarily reflect these data. Reporting as speaking only Spanish were 49.2%, whereas those who speak half Spanish and half English were 30.8% and those who speak more English or only English were 3.1% and 6.2% respectively.

Table 2 represents the places of residency studied; 24.6% live in Florence Heights, 52.3% live either in Hampton Gardens, Meadowbrook or Hampshire Heights (although of this total of 34, 29 live in Hampton Gardens) and 23.1% live in the towns of Northampton (N=12), Forence (N=1), or Easthampton (N=3). A review of Table 2 demonstrates the demographic variables presented as they are distributed according to place of residency. These data will become more relevant in the next section.

The Mental Health Profile

To obtain a profile of the mental health of the Hispanic community

TABLE 2

Percentage of Respondents According to Residency by Demographic Variables

Characteristic	Florence Heights (N=16)	Hampton Gardens, MeadowBrook (N=34)	Town Northampton, Florence (N=15)	p <
Age Subject				
29 and under	68.8	36.4	40.0	NS
30 to 44	25.0	33.3	46.7	
45 and older	6.3	30.3	13.3	
Education				
None to 11th grade	87.5	70.6	26.7	.001
High School and beyond	12.5	29.4	73.3	
Yearly Income				
Less than $6,084	50.0	45.5	14.3	NS
$6,084 - $10,080	50.0	39.4	57.1	
Over $10,080	0	15.2	28.6	

3 main sections are reported: Mental Health Problem List, Family Problem List, and Community Problem List. In addition, significant environmental stress factors are reported.

Mental health problem list. The Mental Health Problem List is composed of thirteen questions about the frequency during the past year of identified problem areas. Table 3 represents the reported frequency of the thirteen mental health problem areas. The highest percentages fall in the category of never or rarely occurring. For example, 52.3% of the respondents report that they do not experience chest, back or stomach pains. Another 52.3% report that they do not often feel like yelling or hitting a wall or someone. Sixty percent report that they do not feel like crying and seventy-six point nine percent never experience anyone calling them or knocking at the door without anybody being there. On the extreme, those respondents who often experience any of the mental health problems never form more than 30% of the sample nor less than 7.7% and have a mean of 19.6% of the total sample of 65 respondents. The problems most frequently reported as occurring often are feelings of energy and not knowing what to do (26.2%); headaches (24.6%); feeling nervous and tense (24.6%); feeling bored with life (21.5%); feeling depressed (20.0%); not sleeping well at night (20.0%); and wanting to yell or hit a wall or someone (20.0%). Cross-tabulation reveals more interesting data, however, Table 4 is a summary representation of cross-tabulations of the 13 mental health problem variables with nine demographic characteristics. Individual tables per demographic factor specifying the frequency scales according to the described variable values and the respec-

TABLE 3

Percentages of Reported Frequency of Mental Health Problems

Mental Health Problem Variables	Never	Sometimes	Often
1. Can not sleep well at night	43.1	36.9	20.0
2. Headaches	30.8	44.6	24.6
3. Feels nervous and tense	27.7	46.2	24.6
4. Has chest, back pain	52.3	33.8	12.3
5. Feels depressed	35.4	44.6	20.0
6. Wants to yell, hit the wall or someone	52.3	27.7	20.0
7. Has much energy but doesn't know what to do	29.2	44.6	26.2
8. Feels like walking out and keep on going	29.2	40.0	30.8
9. Can't stand this situation	44.6	36.9	18.5
10. Bored with life	47.7	30.8	21.5
11. Feels like crying, throwing oneself on the floor	60.0	29.2	10.8
12. Forgets things	33.8	47.7	18.5
13. Feels like some calls him/her or knocks at the door	76.9	15.4	7.7

TABLE 4

Summary of Cross-Tabulations of Mental Health Problems by Demographic Variables

Mental Health Problem Variables	DEMOGRAPHIC VARIABLES								
	Marital Status	Sex	Age	Education	Yearly Income	Residence Area	Number of Children	Where Born	Time U.S.
1. Can not sleep well at night	NS	NS	NS	NS	NS	NS	NS	NS	NS
2. Headaches	NS	.0192	NS	NS	NS	.0089	NS	NS	.0009
3. Feels nervous and tense	NS	NS	NS	NS	NS	NS	NS	NS	NS
4. Has chest, back or stomach pains	NS	NS	NS	NS	NS	.053	NS	NS	.0030
5. Feels depressed	NS	NS	NS	.0104	NS	.0364	NS	NS	NS
6. Wants to yell, hit the wall or someone	NS	NS	NS	NS	NS	.0493	NS	NS	NS
7. Has a lot of energy but doesn't know what to do	NS	NS	NS	NS	NS	NS	NS	NS	NS

TABLE 4 (CONTINUED)

Mental Health Problem Variables	DEMOGRAPHIC VARIABLES								
	Marital Status	Sex	Age	Education	Yearly Income	Residence Area	Number of Children	Where Born	Time U.S.
8. Feels like walking out the door and keep on going	NS	NS	NS	.0478	NS	.0327	NS	NS	NS
9. Can't stand this situation	NS	NS	.0142	NS	NS	.0067	NS	NS	NS
10. Bored with life	NS	NS	.0291	NS	.0427	.0048	NS	NS	NS
11. Feels like crying, throwing oneself on the floor	NS	NS	NS	NS	NS	.0150	NS	NS	NS
12. Forgets things	NS	NS	NS	NS	NS	.0287	NS	NS	NS
13. Feels like someone calls him/her or knocks at the door	NS	NS	NS	NS	NS	.0229	NS	NS	NS

tive percentages are found in Appendix D1.

From Table 4 one can readily see a clustering of problem areas and some emerging patterns. Headaches and being bored with life are significantly related with certain demographic variables more often than any other problem areas. Headaches are significantly related to sex at the .0192 level, to place of residence at the .0089 level and to length of time spent in the United States at the .0009 level. A third of the female respondents (33.3%) often experience headaches as compared to none so experienced by males who reported, however, sometimes having them (64.7%). The residents of Hampton Gardens significantly ($p < .0089$) report headaches more often than residents at Florence Heights and definitely more than the 6.7% of those who live in town. However, when sex is controlled by place of residence, women who live in Hampton Gardens are significantly more prevalent. Table 5 represents this relationship.

TABLE 5

Cross Tabulation of Mental Health Problem 2 (Headaches) by Sex Controlling for Residence: Hampton Gardens

Sex	Percentage of Frequency			X^2	$p < .05$
	Never	Sometimes	Often		
Male (N=7)	0	100	0	7.8353	.0199
Female (N=27)	18.5	40.7	40.7		

When sex is controlled for by yearly income, a significant relationship ($p < .0139$) occurs. Women whose yearly income was less than $6,084 more frequently experienced headaches and also were more frequently represented in this income level (76.0%). An inverse relationship (.001) occurs as related to length of stay in the United States. Those who have lived in the United States 15 years or more (38.5%) report that 44% never have headaches and none experience them often, although 47.8% of those who've lived in the United States from 7 to 14 years report that they often have headaches.

Being bored with life (Mental Health Problem 10) relates significantly to age (.0291), to yearly income (.0427), and to place of residence (.0048) as seen in Table 4. Examining age, the older the person, the less the probability that they feel bored with life. Of those respondents between ages 30 to 44, 63.6% reported that they never feel bored and of those 45 years and older, 69.2% reported that they never feel bored with life. Of the below 30 group, 44.8% reported feeling bored sometimes and 27.6% felt this way often. When income is considered those in the middle to higher brackets ($6,216 and over $10,000) reported that 55.2% and 77.8% respectively never feel bored. Of those whose incomes was less than $6,084, 36% reported often or sometimes feeling bored with life to the 28% that never do. When we look at the significant ($p < .0043$) relationship between place of residence and mental health problem 10, we find that 50% of those who live in Florence Heights often feel bored with life whereas only 8.8% of the Hampton Gardens residents do and 20% of those who live in town respond to often

feeling bored. Further, a cross tabulation of Mental Health problem 10 by sex controlling for residence reveals that 53% of the women who live in Florence Heights often feel bored with life. Table 6 represents this relationship.

TABLE 6

Cross Tabulation of Mental Health Problem 10 (Bored with Life) by Sex Controlling for Residence: Florence Heights

Sex	Percentage of Frequency			X^2	$p < .05$
	Never	Sometimes	Often		
Male (N=1)	100	0	0	7.466 with 2DF	.0239
Female (N=15)	6.7	40	53.3		

Relating significantly to two demographic characteristics are Mental Health problems 4, 5, 8 and 9. Mental Health problem 4 refers to experiencing chest, back or stomach pains and was significant at the .053 level with place of residency and with length of stay in the United States ($p < .0030$). Of those residents who lived in town (N=15), 86.7% reported that they never experienced this problem compared to 43.8% and 42.4% respectively of the residents of Florence Heights (N=16) and Hampton Gardens (N=34). As often experiencing these pains were 18.8% of the respondents of Florence Heights and 15.2% of those in Hampton Gardens. And of those respondents who had lived longer in the United States, over 15 years (n=24), 75% never or rarely had back pains although 52.9% of those who had lived 6 years or less (N=17) also never

or rarely had these pains.

Mental Health Problem 5 asks how often the respondent feels depressed. Table 3 indicates that 20% of the respondents (N=13) often feel depressed, that 44.6% (N=29) sometimes feel depressed but that 35.4% (N=23) rarely or never feel depressed. Cross tabulation reveals that a significant interaction exists with educational level ($p < .0104$) and with place of residence ($p < .0364$). Those respondents with high school or more (N=23) report that 47.8% never feel depressed and that 52.2% sometimes do, but those with less than an 11th grade education (N=42) report that 31% of them often feel depressed whereas 28.6% never do. Examining the significant interaction with place of residence we find that whereas 43.8% of the residents of Florence Heights (N=16) often feel depressed, only 14.7% of the residents of Hampton Gardens (N=34) often feel depressed, and even less the residents in town (N=15) with a 6.7% of the respondents reporting that they often feel depressed.

Mental Health problem 8 ("feel like walking out...") similarly has significant interaction with educational level ($p < .0478$) and residence ($p < .0327$). Of the total sample of 30.8% (which is the highest percentage obtained) report that they often experience feelings of wanting to walk out of their homes and keep going. Looking at the educational level, 40.5% of those with less than 11th grade report that they often feel this way whereas only 13% of those with high school or more report having these feelings. The place of residence again reveals that residents of Florence Heights are expressing different levels of stress. Mental Health problem 8 is

experienced often by 62.5% of the Florence Heights residents, by 20.6% of the residents of Hampton Gardens, and by 20% of those who live in town.

Mental Health problem 9 ("can't stand this situation") significantly interacts with age levels ($p < .0142$) and residence areas ($p < .0067$). Of the total sample, 44.6% report this as never occurring. In age group 30 to 44, 63.6% report that they never feel this way, and 61.5% of those 45 and older report that they never feel this way. The younger group (under 30) report that 24.1% of them (N=29) never feel like they can't stand their situation any longer. Residents of Florence Heights report that 37.5% of them often feel they can't stand their situation, but only 8.8% of the Hampton Garden residents and 20.0% of the town residents report feeling that they often can't stand their situation.

Mental Health problems 6, 11, 12 and 13 are each significant at .0493, .0150, .0287, and .0229 levels respectively with place of residence. In each situation residency at Florence Heights showed higher percentage in both categories of sometimes and often. Table 4 clearly illustrates that residence more than any other demographic variable is 10 out of 13 times significantly related to the mental health problems.

Family problem list. The Family Problem list is formed by 9 items which identify areas that can function to create familial stress and conflict. Respondents were asked to identify the frequency with which they perceived each problem occurred in families in their community. Table 7 illustrates the frequency findings for the family problem items. Detailed tables of the family problem items are found in Appendix D2.

From Table 7 we can see that the reported incidence of possible

TABLE 7

Percentage of Reported Frequency of Family Problems

Family Problem Items	Percentage of Frequency		
	Never	Sometimes	Often
1. Harsh discipline by parents	23.1	43.1	15.4
2. Lack of discipline by parents	10.8	38.5	38.5
3. Lack of attention or neglect of children	10.8	27.7	46.2
4. Poor understanding between parents and children	10.8	27.7	38.5
5. Economic frustration	15.4	21.5	44.6
6. Divorce	29.2	26.2	23.1
7. Alcohol use	26.2	20.0	41.5
8. Drug use	30.8	20.0	32.3
9. Emotional problem	27.7	30.8	20.0

neglect of children (46.2%), of economic frustrations (44.6%) and alcohol use (41.5%) are identified as occurring with greater frequency than other problems. Lack of discipline by the parents and poor understanding between parents and children are identified as occurring often by 38.5% of the respondents. Drug use was reported as occurring often by a little less than a third of the respondents (32.3%). Divorce is reported as occurring often by 23.1% of the sample, followed by emotional problems with 20.0%, although 30.8% report that emotional problems sometimes occur.

The results of cross-tabulations of the family problem variables with six demographic characteristics is represented by Table 8.

Divorce and drug use are more often significantly related to particular demographic characteristics than other family problem items. Drug use is significantly related to marital status of respondent ($p < .0032$), to age of respondent ($p < .0169$), and to yearly income of respondent ($p < .0276$). Married respondents identify this problem as occurring more frequently (51.5%) than do single persons (19.0%). Respondents in the age group between 30 and 44 years identify drug use as occurring often according to 50% of them, whereas in the under thirty group 40% state that this problem occurs often, and 20% of the people over 45 identify this problem as occurring often. A significant interaction with income levels reveals that 52.2% of the respondents in the income group between $6,210 and $10,080 perceive drug use as occurring often whereas 14.3% of the higher income group respondents identify this problem as occurring often. In the lower income group 36-40% report

TABLE 8

Summary of Cross-Tabulations of
Family Problems by Demographic Characteristics

Family Problem Items	Demographic Characteristics					
	Marital Status	Sex	Residence	Age	Where Born	Yearly Income
1. Harsh discipline	NS	NS	NS	NS	NS	NS
2. Lack of discipline	NS	NS	NS	.0077	NS	NS
3. Neglect of children	NS	NS	NS	NS	NS	.0410
4. Poor relations parent-child	NS	NS	NS	NS	NS	NS
5. Economic frustrations	NS	NS	NS	NS	NS	NS
6. Divorce	NS	NS	.0303	.0042	NS	NS
7. Alcohol use	NS	NS	NS	NS	NS	NS
8. Drug use	.0032	NS	NS	.0169	NS	.0276
9. Emotional problems	NS	NS	NS	NS	NS	NS

drug use as a family problem which occurs often.

Divorce is significantly related to place of residence ($p < .0303$) and age ($p < .0042$). Perception of divorce as a family problem is identified most frequently by town residents, 50% of which report this problem as occurring often compared to the 22.6% of Hampton Gardens and the 25% of Florence Heights. Age-wise, the older the respondent, the greater the percentage who do not identify divorce as a major family problem. Of the problems identified by a greater number of the respondents, lack of attention or neglect of children is significantly related to yearly income ($p < .0410$). We find that 41.7% of those in income levels below $6,084 identify this problem as occurring often. But as income level increases to the $6,216 to $10,080 range, so does the reporting of this problem increase to 73.9% of the respondents claiming it occurs often. Only 28.6% of the respondents with incomes over $10, 176, however, report this as a frequent problem. If we review what place of residence is most related to yearly income levels, we come up with the following: 50% of the Florence Heights residents fall into the less than $6,084 level and 50% into the $6,084 to $10,080 level; 45.5% of the Hampton Garden residents fall into the lowest level, 39.4% into the middle and 15.2% in the over $10,080 level; only 14.3% of the town residents are in the lowest income category, 57.1% in the middle level, and 28.6% in the higher income level, comparatively.

Community problems list. The community problem items are 10 problem areas that respondents were asked to identify as existing in their immediate community according to a frequency scaling. Table 9 represents

TABLE 9

Percentages of Reported Frequency of Community Problems

Community Problem Item	Frequency		
	Never	Sometimes	Often
1. Abuse or neglect of children	33.8	27.7	16.9
2. Parents who provide poor examples	21.5	29.2	35.4
3. Dominating children	24.6	26.2	35.4
4. Wife abuse	16.9	24.6	43.1
5. Husband abuse	40.0	27.7	10.8
6. Vandalism by community	29.2	32.3	27.7
7. Vandalism by others	15.4	27.7	46.2
8. Aggressive children	26.2	33.8	33.8
9. Drug use	21.5	16.9	44.6
10. Alcohol use	20.0	15.4	53.8

the percentage of respondents that identify different problems as existing in their community.

From this table we can see that the problems which were identified as occurring more often in the Hispanic community are wife abuse (43.1%), vandalism by non-community members (46.2%), drug use (44.6%), and alcohol use (53%). Concern about dominating and aggressive children's behavior was identified by 35.4% and 33.8%, respectively, of the respondents. Those that are perceived by a greater percentage of respondents as never or rarely occurring are husband abuse (40.0%) and child neglect or abuse (33.8%). It is interesting to note that a similar item on the family problem list, which asked about the lack of attention or neglect of children was identified by 46.2% of the respondents as occurring often, and 10.8% reported this as never or rarely occurring. In the present list, this similar item is identified as occurring often by 16.9% of the respondents, and as rarely or never occurring by 33.8%.

A summary of cross-tabulations of the community problem items with six demographic variables is represented in Table 10.

Detailed tables of the community problem items are found in Appendix D3.

Table 10 reveals that place of residence is significantly related to community problems perceived as existing in that community 4 out of 10 times and age is significantly related 3 out of 10 times. Sex and yearly income are each significantly related one out of the ten problem areas.

Place of residence is significantly related to wife abuse ($p < .054$),

TABLE 10

Summary Cross Tabulations of Community Problems by Demographic Characteristics

Community Problem Items	DEMOGRAPHIC CHARACTERISTIC					
	Marital Status	Sex	Place of Residence	Age	Education	Yearly Income
1. Abuse or neglect of children	NS	.0119	NS	NS	NS	NS
2. Parents who provide poor examples	NS	NS	NS	.0016	NS	NS
3. Dominating children	NS	NS	NS	NS	NS	NS
4. Wife abuse	NS	NS	.054	.0487	NS	.0445
5. Husband abuse	NS	NS	NS	NS	NS	NS
6. Vandalism by community members	NS	NS	.0119	NS	NS	NS
7. Vandalism by others	NS	NS	.0246	.0125	NS	NS
8. Aggressive children	NS	NS	.0273	NS	NS	NS
9. Drug use	NS	NS	NS	NS	NS	NS
10. Alcohol use	NS	NS	NS	NS	NS	NS

to vandalism by community members ($p < .0119$), to vandalism by non-community members ($p < .0246$), and to aggressive behavior in children ($p < .0273$). High percentages of residents of Florence Heights report these problems as occurring often in their community. Wife abuse is reported as occurring often by 62.5% of the Florence Heights residents, by 37.5% of the Hampton Garden residents, and interestingly by 60% of the town residents. Vandalism by community members is reported as occurring often by 56.3% of the Florence Heights residents, only by 10.3% of the Hampton Garden residents, and by 46.2% of the town respondents. Vandalism by non-community members is reported as occurring often by 81.3% of the Florence Heights respondents, by 32.1% of the Hampton Garden respondents, and 37.1% of the town residents. Aggressive children are reported as a problem occurring often by 62.5% of the Florence Heights residents, by 19.4% of the Hampton Garden residents, and 42.9% of the town residents.

Age is significantly related to 3 community problem items: parents who provide a poor image or example ($p < .0016$), wife abuse ($p < .0487$), and vandalism by non-community members ($p < .0127$). Wife abuse is perceived as a community problem occurring often by 51.9% of the respondents under 30, by 61.1% of those between 30 and 44 years, and by 33.3% of those 45 and older. Vandalism by non-community members is perceived as occurring often by 61.5% of those under 30, by 47.4% of those between 30 and 44 years, and by 41.7% of those 45 and older. Children with aggressive behaviors is identified as occurring often by 48.1% of the under 30 group, by 33.3% of those between 30 and 44 years

and only by 16.7% of the respondents 45 years and older. With the exception of wife abuse, the under 30 group identify these community problems as existing in their communities with greater frequency.

Sex of the respondent is significantly related to perceived community problem item of abuse or neglect of children ($p < .0119$). Forty-six percent of the males report this problem as occurring often, whereas only 11.1% of the females identify abuse or neglect of children item as occurring often.

Yearly income is also significantly related to one community problem item. Wife abuse is significant at $p < .0445$. Of the respondents in income range less than $6,084, 37.8% perceive this problem as occurring often. Of those in income range between $6,216 and $10,080, 72.7% identify this problem as occurring often whereas 37.5% of those in the $10,176 and over income range state this problem as occurring often in their community.

This then summarizes the significant results of the cross-tabulations of the community problem items to demographic variables.

This mental health profile focuses on the results of the items to three sub-sections of the survey instrument: mental health problems, family problems, community problems. However, and as stated earlier, other related problems help to round out this profile. Environmental stress factors provide data that can further contribute to this profile. Two items that inquire into environmental stress factors are the incidence of neighborhood fights and vandalism. Table 11 and Table 12 reveal that these two factors are significantly related to place of

TABLE 11

Percentages of Reported Frequency of
Neighborhood Fights by Place of Residence

Residence	Frequency			X^2	p <
	Never	Sometimes	Often		
Florence Heights (N=16)	0	5.9	68.2	39.32 with 4DF	.001
Hampton Gardens (N=33)	56.0	82.4	22.7		
Town of Northampton and Florence (N=16)	44.0	11.8	9.1		

TABLE 12

Percentages of Reported Frequency of
Neighborhood Vandalism by Place of Residence

Residence	Frequency			X^2	p <
	Never	Sometimes	Often		
Florence Heights (N=16)	0	14.3	68.4	36.722 with 4DF	.001
Hampton Gardens (N=34)	52.0	71.4	31.6		
Town of Northampton and Florence (N=15)	48.0	14.3	0		

residence. Neighborhood fights are significantly related to residence at $p < .001$ and neighborhood vandalism is significant at $p < .000$. Residents of Florence Heights report these problems as occurring often in their community in higher percentages than residents in other surveyed Hispanic communities. Sixty-eight percent of the respondents of Florence Heights report neighborhood fights as occurring often (none reported that they never occur), whereas 22.7% of the Hampton Garden residents report fights occurring often in their community, and only 9.1% of the town residents identify this. Vandalism is likewise reported as occurring with greater frequency by the Florence Heights respondents. Sixty-eight percent report vandalism as often occurring, 31.6% of the Hampton Garden respondents report vandalism as occurring often and none of the town residents report this as occurring often in their community. These factors when seen in conjunction with the other results point out the neighborhoods in which residents are more subjected to stress and which indicate so by their mental health profile.

Identified Needs and Human Service Use and Preferences

This last section of the results reports on those survey items which probed into the specific problems and needs the respondents identified, their use of human services, and their human service provider preferences.

The surveyed population was queried on the two problems they felt were the most prevalent in the Hispanic community in general and for which services were needed. Table 13 lists the frequencies to the open-

TABLE 13

Frequency of Respondents Identification of Problems Affecting the Hispanic Community

Identified Problem	Frequency of Response	Percentage of Total Sample (N=65)
Employment	12	18.46
Drugs	11	16.92
Housing	10	15.38
Economic (poverty)	8	12.30
Discrimination & Racism	7	10.76
Emotional	5	7.60
Education	5	7.60
Health	5	7.60
Adolescents	5	7.60
Alcohol	4	6.15
Language	3	4.61
Nutrition	2	3.07
Children	2	3.07
Recreation	2	3.07
Political awareness	2	3.07
Legal	2	3.07
Aware of rights & resources	2	3.07
Elderly	1	1.53
Adjustment to Anglo culture	1	1.53
Wife abuse	1	1.53
Marital understanding	1	1.53
Vandalism	1	1.53
Need for more religion	1	1.53
Don't know	30	46.15
No answer	7	10.76
2 Responses per respondent =	30	

ended responses given by the respondents. From this table we can see that the problems identified most frequently were employment needs, drug related, housing needs and economic needs. Discrimination, emotional, educational, and health problems fall in the middle range along with problems with adolescents and alcohol. On the lower end, the respondents identified an array of problems from language, legal, recreational needs to wife abuse and need for marital understanding to adjustment to Anglo culture. Although this table does not limit the identified problem areas to mental health, it allows us to appreciate areas that are related to the mental health of a community and which are the expressions of most concern of the Hispanic community under study.

In order to obtain information on the kinds of issues the respondents wanted or felt they needed help with in the form of educational workshops, eleven items were prepared. Table 14 lists the different areas tapped and the response frequencies to each one.

This table reveals a relatively high percentage of interest in educational workshops which could provide a preventive mental health focus. They may also be indicative of mental health concerns that are not expressed in other areas, or, on the contrary, they may reflect degrees of social desirability responses. Nevertheless, we can observe that the highest percentage (67.7%) is attributable to concern over the impact of social and economic situations on family life. This interest is also reflected by three other related workshop themes with the next highest interest rates: improvement of family relations (64.6%), emotional stress and problems (64.6%), and survival skills (66.2%).

TABLE 14

Identified Workshop Interests

Workshop Themes	Frequency of Identified Interest	Percentage (N=65)
1. Child rearing problems	41	63.1
2. Problems with adolescents	32	49.2
3. Improve marital relations	33	50.8
4. Single mothers	35	53.8
5. Drug rehabilitation of young adults	33	50.8
6. Alcoholism	34	52.8
7. Improve family relations	42	64.6
8. For young adults on improving family life	31	47.7
9. Emotional stress and problems	42	64.6
10. Survival skills	43	66.2
11. The impact of social and economic situation on the family	44	67.7

Concern with childrearing problems is also relatively high (63.1%). What can be seen by these themes is the interrelation of socio-economic factors with matters of familial well-being. The other workshop themes with 50% or more interest relate to improving marital relations (50.8%), needs of single mothers (53.8%), rehabilitation of young drug users (50.8%), and alcoholism (52.8%).

These findings, however, are in marked contrast to the actual use of mental health services and knowledge of human service agencies in the area. Table 15 reveals the responses to questionnaire item #68 as to whether the interviewee had used any mental health services within the past year.

TABLE 15

Frequency of Use of Mental Health Services
in the Past Year

Response Category	Frequency (N=65)	Percentage
Yes	4	6.2
No	61	93.8

This table certainly reveals very scant use, although maybe not need, of mental health services in the area. An investigation of agency records could substantiate or refute these findings. If we compare the above table to the following one on the use of medication for the "nerves," a slight discrepancy can be observed.

TABLE 16

Use of Medication for "Nerves"

Response Category	Frequency (N=65)	Percentage
Yes	9	13.8
No	55	84.6

Both of these tables may reflect social desirability responses and may not represent an accurate situation. When we examine the respondents knowledge of human service agencies in the area, as seen in Table 17, we can confirm the lack of knowledge and use of human service agencies in the area. Noticeably the two most frequently used agencies are the Casa Latina (38.5%) and the New England Farmworkers Council or as it is commonly called, "El Gallo" (32.3%). Casa Latina is a multipurpose center staffed by Hispanic community members and El Gallo is an educational and social facility. Neither of these agencies, however, provide mental health services. The two agencies which do, in a more general capacity than the others in this list, the Children's Aid and Family Services (CAFS) and the Franklin Hampshire County Mental Health Center (FHCMHC) are rarely, if ever, used. Knowledge of the existence of these services is limited also with 58.5% having no knowledge of CAFS and 70.8% not knowing about the FHCMHC.

If we investigate further the findings as to the human services provider preferences of our sample, some of the previous results can be

TABLE 17

Percentage Knowledge and Use of Area Human Services

Agency	Knowledge of or Use of Services		
	No	Yes	Have Used
Alcoholic Prevention Program	36.9	60.0	3.1
Children's Aid and Family Services	58.5	36.9	3.1
Casa Latina	4.6	55.3	38.5
Family Planning Council	50.8	44.6	3.1
Franklin Hampshire County Mental Health Center	70.8	27.7	0
Help for Children	64.6	35.4	0
Networks	83.1	17.0	0
Threshold	70.8	27.6	1.5
Youth Employment Service	41.5	55.4	3.1
New England Farmworkers Council	9.2	58.5	32.3
H.C.A.C.	53.8	38.4	6.2

explained. Respondents were asked to identify to whom they prefer to consult with when they experience any emotional difficulty. This question was asked by two different items. Table 18 represents the results as grouped into four categories for the first item and Table 19 represents the results for the second item.

TABLE 18

Percentage of Preferred Consultant for Emotional Difficulty

Category of Consultant-Therapist*	Frequency (N=65)	Percentage
No one	17	26.2
A family member	18	27.7
A community member	18	27.7
Mental health professional	12	18.5

TABLE 19

Preferred Consultant for Mental Health

Category of Consultant-Therapist	Frequency (N=65)	Percentage
No one	16	24.6
A family member	17	26.2
A community member	20	30.8
Mental health professional	12	18.5

*To facilitate data analysis the category of community member represents friends, community members and religious persons. The category of mental health professional groups counselors, social workers, psychologists and psychiatrists.

The similarity between both of these tables helps formulate a more concrete picture of the provider preferences that the Hispanic community has. Further, when questioned on who they would hire, if they could, to staff services for Hispanics, the following results emerged.

TABLE 20

Hiring Preferences of Survey Respondents
to Human Service Positions

Category of Provider	Frequency (N=65)	Percentage
No one	19	29.2
A family member	14	21.5
A community member	21	32.3
A mental health professional	7	10.8
(Missing)	4	6.2

We can see that approximately one-fourth of the respondents do not wish to consult or hire anyone. Approximately between 21.5% to 27.7% would resort to a family member to consult their emotional difficulties, whereas from 27.7% to 32.3% would prefer a community member. In all three tables, however, the recurrence to a mental health professional is the least preferred choice with an 18.5% in the first and second tables to 10.8% (7 persons) stating that they would hire one. A further examination into specific categories reveals that in the category of community member, resort to a friend is significantly more frequent than any other community person. This can be observed in Table 21 for all three questionnaire items.

TABLE 21

Break-down of Community Member Consultant Preferences

Table in Reference	Community Member Break-down by Percentages			
	Friend	Member in Community	Priest	Spiritist
Number 18	23.1	1.5	3.1	0
Number 19	23.1	1.5	6.2	0
Number 20	32.2	3.1	1.5	3.1

These findings reveal that friends in the community are more frequently entrusted with the task of co-counselors and helpers as reported in this sample. The implications of this for program planning will be discussed in the final chapter. To be noted also, is the extremely low preference for an "espiritista" or a spiritist as reported by only 1 respondent. This is contrary to a widely held belief that Puerto Ricans resort frequently to spiritualists as indigenous mental health providers. To what degree, however, this finding is reflective of social desirability and other response bias factors must be further investigated. For our sample we can at best speculate on the significance of this finding in the discussion chapter to follow.

In summary, this last section of results concludes the major findings of the survey of the mental health needs and problems of the Hispanic community under study.

C H A P T E R V

DISCUSSION AND CONCLUSIONS

Introduction

This final chapter has a threefold purpose. First, to discuss the salient findings of the survey in light of the literature and the purpose of this study. The results include the profile of the community respondents, the mental health profile and the identified needs, and human service use and preferences.

Second, to offer some tentative conclusions and recommendations as to the mental health related services needed by the Hispanic community in this sample. In this way, this research endeavor can fulfill one of its metatheoretical goals in that its findings can be of benefit to the participants and subjects of the study instead of exclusively to the principal investigator.

Third, to discuss the methodology in terms of its limitations, its effects upon the findings of the survey, its effects upon the participating Hispanic youth, and finally, its relevance to the development of a participatory research practice.

The Survey Results and Their Implications

Who are the Hispanics in this sample? What are their mental health problems and needs? The contours of the Hispanic community under study reveal a primarily female respondent population, with a mean age of 34

years, married with two children, born in Puerto Rico, with a mean educational attainment of ninth to eleventh grade and living primarily from salary income or welfare benefits. The women, as compared to the men in this sample, have significantly attained a lesser educational level. The average yearly income is $7,270, although the most frequently reported income was $3,600. The mean number of years living in the United States is 14 years, although approximately 35.4% have been on the mainland for less than nine years. The prevalent use of Spanish at home is 44.2%, although 30.8% speak a combination of Spanish and English. Slightly over one-half of the respondents are residents of the Hampton Garden area, approximately one-fourth are residents of Florence Heights, and about one-fourth reside in the combined towns of Northampton, Florence, and Easthampton. On closer examination, the residents of Florence Heights are younger than those of the other two areas; they have a majority of women, less educational attainment, and the largest percentage of residents with an income of less than $6,084.

The demographic profile of this Puerto Rican community is in many ways consistent with the findings of the 1976 report on Puerto Ricans on the mainland (U.S. Commission on Civil Rights, 1976), and with other descriptive data available (Florez, 1978; Dieppa and Montiel, 1978; U.S., President's Commission on Mental Health, Report, 1980). We can say with some degree of certainty that this sample is similar to certain other Puerto Rican communities in the United States. This has some important implications. First, that the survey instrument approximates valid data. Second, that the questionnaire, as was methodologically

developed, is not only a viable alternative in the preparation of survey instruments, but a feasible research approach. Third, that the results of this survey identify the mental health problems and needs of the Hispanic community and consequent recommendations based on these imply significant program planning and action. Throughout this chapter we will attend to these three general implications.

The mental health profile of the Hispanic community reflects a population with stressful social, economic and environmental situations. The composite results of the three problem lists provide related findings, although some contradictions are evident. From the identified mental health problems, we can group these into three general categories: a) those items expressing general dissatisfaction, unhappiness and frustration (Mental Health Problems 5, 7, 8, 9 and 10); b) those reflective of somatic complaints (Mental Health Problems 1, 2, 3 and 4); and c) those suggesting more serious decompensation (Mental Health Problems 6, 9, 11, 12 and 13). The salient findings indicate that many respondents express general dissatisfaction, unhappiness and frustration. Over 30 percent expressed a feeling of wanting to "walk out and keep on going," and 26.2% having much energy and not knowing what to do. Within this group also fall the 21.5% who are "bored with life," 20% who "feel depressed" and 18.5% who indicate that they "can't stand their situation." The number of respondents whose coping style suggests avoidance will later be related to the perceived and identified family and community problems.

The findings reflective of somatic complaints have the third high-

est percentage in two different categories, namely headaches (24.6%) and feeling nervous and tense (24.6%). Difficulty with sleeping (20%) are fifth highest, along with two other items ("feeling depressed" and "wanting to yell, hit the wall or some one"). Those items suggestive of more serious decompensation are higher in two categories and relatively low in the other three. "Feelings of wanting to yell, hit the wall or someone" are expressed by a fourth of this sample, and forgetting things are experienced by 18.5%. The other items, namely wanting to cry, throwing oneself to the floor and feeling like someone calls him or her or knocks on the door are expressed by less than 11% of this sample, that is, six respondents.

If we look at what were perceived as the most salient family-related problems, we find that neglect of children, economic frustrations and alcohol use are considered as occurring by approximately 41% to 46% of the respondents. Problems with children and poor familial relations are identified by 38.5% of the respondents. Further, the salient problems that are identified as community problems confirm those perceived as occurring in the individual families, with one exception. Abuse or neglect of children is reported as occurring often by 46.2% of the respondents in the family problem list and only by 16.9% in the community problem list. This discrepancy needs to be further examined given its implication for services. Alcohol use, vandalism, drug use and wife abuse are identified by over 40% of the respondents and problems with children and parents by about a third of the sample.

From this finding we can suggest some relationships between the

dence at Florence Heights is significant with various indications of stress, personal discomfort and familial and community problems. Florence Heights is also the poorest community with the lowest yearly income, the one with the youngest population, and with the lowest educational attainment. In Florence Heights a significant percentage of respondents are bored, depressed, feel like walking out and express that they can't stand their situation. This population of respondents was overwhelmingly composed of women. It is also in Florence Heights where vandalism, neighborhood fights, wife abuse, and aggressive children are significantly identified or reported. Of the three areas of residency, then, Florence Heights emerges as the Hispanic community with the most pressing social and mental health problems and needs.

Hampton Gardens has a similar profile, although not as critical. Hampton Gardens was identified as including the residents of Hampton Gardens, Hampshire Heights and Meadowbrook and makes up 52.3% of the sample. Female respondents make up 79.4% of the residents. Slightly over a third of the respondents are under 29, a third are between 30 and 44 years and slightly less than a third are over 45 years. The majority of the respondents have less than 11th grade (70.6%) and approximately over one fourth (29.4%) have achieved high school or more. The income levels also show some variability with 45.5% making less than $6,084, 39.4% in the middle range, and 15.2% in the over $10,080 level. This variability and spread of ages, education and income is not the case for Florence Heights. Of the problems respondents in Hampton Gardens report, headaches are significant for women, and feeling like walking

out are reported by 20%, wife abuse by 37.5%, and aggressive children by 19.4%.

When we consider the literature on the relationship between economic situation or social class and mental health, these findings are not surprising. An inverse relationship between social class and the role of economic conditions and the incidence of mental health problems has been postulated by various studies. An early study, that of Faris and Dunham (1939), reported a relationship between poverty and psychiatric hospitalizations. The famous New Haven study of Hollingshead and Redlich (1958) greatly contributed to exploring this relationship. The Midtown Manhattan study (Srole, et al., 1962) measured psychological impairment as related to class and found a strong inverse relation. Dohrenwend and Dohrenwend (1965) reviewed studies of social class and psychopathology and concluded that the relationship between low socio-economic status and high rates of psychopathology could be considered "an important source of working hypotheses." Other studies have also found that low socio-economic status correlates with high frequency of mental illness (Dohrenwend, 1966; Dohrenwend and Dohrenwend, 1969; Fabrega, Swartz, and Wallace, 1968; Malzberg, 1965).

A related literature is that of the role of stress in precipitating mental health problems. Langner and Michael (1963), in an examination of the Midtown Manhattan study data, found support for the hypothesis that, given more stress among the lower socio-economic classes, a higher rate of psychological impairment was observed. Dohrenwend and Dohrenwend (1965) contend that situational stress factors are central in

behavioral and emotional responses which are seen as symptomatic of psychological dysfunction. They state that many stressors are over-represented in lower classes, which can explain the high rates of psychological disorders among lower class persons. Liem and Liem (1978) suggest that the above authors overlook "the possibility that much of the rated symptomatology in the lower classes may be stress-related and persistent as a function of the chronicity of stressors in the circumstances of lower class life" (p. 142). Brenner's (1973) work also supports the hypothesis that economically-related stress has (a significant role) in the interaction of social and environmental conditions and psychological dysfunction. The impact of unemployment was explored by Levin (1975), who found that unemployed working-class men experienced feelings of lower self-esteem, estrangement and cognitive distortions. Wilcock and Franke (1963) reported similar findings on the impact of lack or loss of income on psychological well-being and relations with significant others. Catalano and Dooley (1977) found in their study that unemployment was significantly related to both depressed mood and stressful life events. They concluded that the unemployment rate seems to be the best single preditor of community mental health indices and assumed that "stressful life change and depressed mood are precursors to mental disorder and service demand..." (p. 305).

The attempt to define the socio-demographic correlates of psychological difficulties and mental disorder offers a broad literature for examination; from the above brief overview, we can appreciate the strong suggestions of the relation between social class and economic situation

subjective mental health problems, family problems and community problems. The unhappiness and frustration identified by some of the mental health problems, particularly feelings of wanting to walk out of a situation, seem to be related to the neglect of children, to economic frustrations and to the use of alcohol. Being bored with life and feelings of depression likewise seem related to economic frustration and to the use of alcohol. Feelings of not knowing what to do with one's energy may be channeled through alcohol use, drug use or frequent fights and vandalism. The somatic complaints, particularly headaches and feelings of nervousness and tension, can relate to problems with children and to economic frustrations. Feelings of wanting to yell or hit someone can relate to the identified wife abuse, economic frustrations, child abuse, alcohol use and to the reported poor example some parents provide. These suggested relationships are further accentuated when we consider the significant interactions between demographic variables and the subjective, familial and community problems. The singlemost frequent significant demographic variable in all three problem lists was place of residency. Place of residency was significantly related to ten of the thirteen mental health problems, to one of the nine family problems, and to four of the ten community problems. Age was the next most frequent significant demographic variable. Age was significant with two mental health problems, with three family problems and with three community problems. Yearly income was significant four times, sex twice, education twice, and time in the United States twice. Focusing on the significant interactions with residence, we repeatedly find that resi-

They contend that:

> Since the stresses women experience are often generated in the broader social context, political action can advance the cause of women's well being and mental health. To the extent that depression is a disease of powerlessness and hopelessness, political efforts to broaden women's options and their ability to control their own lives and improve their futures should aid the cause of women's mental health (p. 156).

Certainly some of the parameters of the mental health difficulties women experience are associated with their economic situation, marital status, age and similar socio-demographic factors. Environmental factors have also been found to affect lower class women's physical and mental health (Duvall and Booth, 1978). The findings of our study that poorer and lesser educated women living in the worst housing situations report higher rates of dissatisfaction, boredom, restlessness and depression is not at variance with the general literature.

The composite findings that the Hispanic community reports greater dissatisfaction, frustration and depressed moods; that it expresses somatic complaints; that it identifies problems with children, drugs and alcohol, economic frustrations and vandalism as their salient family and community concerns; that it identifies its major general problems as unemployment, housing, and economic stress, are all findings which are consistent with the literature on Puerto Ricans and mental health. In the literature review, various findings were reported that are particularly relevant to the results of this study. Srole (1962), Dohrenwend and Dohrenwend (1969), Haberman (1970) have all found more psychiatric symptomatology among Puerto Ricans, particularly as measured by psychophysiological terms. Abad and Boyce (1979) from their

to a community's mental health. Although the findings of the current study can not be defined as epidemiological research findings, we can appreciate some similarities between the findings from this body of literature and the results of this study.

In terms of the significant problems reported mainly by female respondents, particularly significant with residency in Florence Heights and in Hampton Gardens, we find that our findings are also supported by the research literature. The experience of women, particularly as housewives and mothers, has been found to be stressful and associated with the preponderance of emotional difficulties among women (Gove and Geerken, 1977; Gove and Tudor, 1973; Weissman and Klerman, 1977). In a recently published study (Brown and Harris, 1978), the authors attribute the clinical depression of working class women to the influences of social factors on their daily lives and experiences. Dohrenwend (1973) points out that lack of power over their lives is associated with the psychological problems women experience. Recent literature on the critical mental health situation of women makes some similar and important observations. For example, Al-Issa (1980) states that:

> I have emphasized social factors in order to explain the excessive involvement of women with the psychiatric profession. In particular, I have documented the well-known fact that low social status and lack of power make people--both men and women--more vulnerable to the accusation of madness. The association between being female and being mad may reflect the fact that women have little power to control their destiny and their traditional roles as housewives and homemakers (p. viii).

Further, Belle and Salasin (1980) point out that:

> While women are not overrepresented in mental health facilities, they do suffer disproportionately from depression (p. 155).

clinical cases pointed to the high frequency of somatic complaints, depression, anxiety, and actual or feared loss of control. They also noted the different manifestations of these problems. Our findings of depression, frustration, headaches, feelings of wanting to walk out, of wanting to hit someone or yell, and the manifestations of most concern to the respondents, such as drug and alcohol use, vandalism, problems with children, wife abuse are in resonance with this literature. Even if we attend to Dohrenwend (1966) who argues that high symptomatology scores indicate high levels of anomie and not mental disorder, we find that our findings also confirm his definitions of anomie. It is beyond the scope of this study to differentiate these, but we can keep in mind the possible inconclusiveness about interpretations on the psychological dysfunction of Puerto Ricans. This is further substantiated by the findings of Krause and Carr (1978) who, controlling for response set bias, rejected all five of their own hypotheses, some of which contradict the literature. They report that:

> Our research has indicated that there is no significant relationship between psychiatric symptomatology and the migratory status of our Puerto Rican sample. The results suggest that, when acquiescence to health-related items is controlled, any significant relationship between age, sex, migratory status, education and symptomatology disappears. In addition, we found that anomia scores among Puerto Ricans had no bearing on their symptomatology scores (p. 172).

The present study did not control for response set bias and some of our findings do relate reported mental health problems to certain sociodemographic factors. What is more important for the purposes of this study, however, is the identification of potential mental health problem areas and needs and not the confirmation or refutation of the

existing literature, although this can be useful. In summary, the main problems identified by our survey do find support in the literature. Further, the community's concern with drug and alcohol use, employment and housing, reflect problems that affect Hispanics in general. Finally, the community's general concern with its economic situation is supported by the findings of Fitzgibbons, Cutler and Cohen (1971) and of Lehmann (1970) as themes that provoke personal conflict and maladjustment.

Our findings also explored the use of mental health services in the area and provider preference. As has been indicated in the literature, our sample also under-utilizes available mental health services, has little knowledge of available services, and may view them as irrelevant to their needs. Contrary to the widely held belief that low-income Puerto Ricans resort to "espiritistas" or spiritual folk healers, our sample found only one such reported usage. This finding, however, must be viewed carefully, as the use of "espiritistas" may not be admitted openly. On the other hand, if it reflects a true situation, it implies that this community is neither using the recognized folk healers nor the established mental health services. Indeed our findings showed preference for use of a friend as a consultant for emotional difficulties.

In summary, our survey results point out that the Hispanic community is beset by economic, social, and environmental stress. The themes they report of personal distress and of family-community problems are found to be generally interrelated to their socio-economic situation and any recommended services must be attentive to this.

Human Services to the Hispanic Community

An important and integral part of this study was to identify mental health problems and needs in order to plan and develop relevant and appropriate services for the Hispanic community. Based on the findings and discussion, the following recommendations are seen as necessary steps towards addressing the mental health needs of the Hispanic community.

First, given that the Hispanic community is mainly Spanish-speaking bilingual human service providers would be needed.

Second, that given the mental health profile of the Florence Heights community, serious consideration of priority intervention in this area is warranted.

Third, that given that women emerge as the most distressed, that their needs be initially addressed by human service providers.

Fourth, that further assessment of drug and alcohol-related problems be carried out in order to determine the scope of the problem.

Fifth, that given the frequency of reported problems with children, that this be another area of top priority for program planning.

Sixth, that social service agencies take note of the reported needs of housing, employment, and economic well-being.

Seventh, that the Hispanic community and community agencies meet to discuss and organize the service needs and plan consequent social actions.

Eighth, that area mental health agencies address the scarcity of bilingual mental health personnel to meet the needs of women, children,

and possible drug and alcohol abusers.

Ninth, that these area agencies prepare Spanish-speaking crisis intervention workers.

Tenth, that these area agencies conduct educational workshops with a preventive focus, taking heed of the identified workshop preferences and identified problems and needs.

Eleventh, that Spanish-speaking outreach workers be trained and hired by area agencies to help increase the acceptance of relevant services by the Puerto Rican community.

Twelfth, that the Hispanic community be consulted and trained towards providing temporary homes in child placement in welfare cases.

Thirteen, that self-help and co-counseling approaches be considered, given the reported provider preference.

And finally, that the main Hispanic community agency obtain funds to hire counselors, outreach workers, therapists as needed, and to develop an educational program of ongoing workshops with an orientation and preventive focus. These could include: Parenting Skills, Single Mothers, Survival Skills, etc. But even more importantly, and as thematic of this entire study, that the Hispanic community participate in the planning, organizing, and implementation of these needed services.

Methodology: Limitations, Impact and Future Implications

An integral part of this study involved the operationalization of a participatory research methodology which could develop and instrumentalize a survey of the mental health problems and needs of an

Hispanic community. Towards this end, the participation of Hispanic youth as co-investigators and of the community in the development of the survey questionnaire, were vital aspects of the process. The degree to which this was accomplished and the degree to which the youths developed a more critical awareness about their social reality and themselves, needs to be examined. To do this we must first look specifically at the limitations and problems encountered.

Limitations which must be recognized relate to the survey instrument itself, the collection of data, the coding process, and group dynamics. Given that the training program to prepare youths for the construction of the questionnaire was time-limited and given the inexperience of the youth, the survey instrument could be improved and refined. Various examples can be cited. The mental health problem list could have been phrased more explicitly, drawing from existing surveys in the literature. Also, items related to eating problems, to anxiety related impairments, and to fatigue could have been included. The family problem list could have differentiated between causes of family problems and symptoms of family conflict. The community problem list could also be improved from this differentiation. Further, items inquiring into psychiatric hospitalizations and a support network could have been included. Finally, the construction of the survey instrument could incorporate controls for response bias as argued by Krause and Carr (1978) and according to the suggestions of Sudman and Bradburn (1974). All these improvements would require more training of the youths. This is also the case for improvement of the data collection.

The youths needed more training and practice with the questionnaire to insure better data recording and use of discrimination to probe interviewees' responses, particularly in limiting the "I don't knows," and other vague answers. Similarly, more practice in the coding of the questionnaire responses could have resulted in fewer errors and missing answers.

The last limitation to be discussed deals with the realities of the participating youths themselves. Granted, the project which they undertook was possibly larger than they were prepared to handle. Training could have dealt with some of the specific tasks of the process, but more elusive factors emerged on a daily basis. For example, the occasional restlessness in sessions required that work periods be highly structured and time-limited to periods no longer than one hour at a time. The tardiness or absenteeism of any member angered the others in some cases, or retarded a planned activity in other instances. The behavior of a few participants exasperated the others. The issue of language, whether to use Spanish or English, frustrated those whose Spanish was poor, and even served to threaten their sense of identity and the group's cohesiveness. The lack of particular skills needed for a specific task resulted in teaching these skills in order to progress with the task.

In summary, a host of factors individually related and group associated intervened in different degrees and at different times of the project. Notwithstanding these problems, this study can document certain effects the project had on the participating Hispanic youth.

This is crucial because it was part of the intent of this process to develop more critical awareness of the social reality of the Hispanic community and of the youths themselves. To attest to this, we can quote exerpts from some of their daily logs which also function as subjective evaluations of the research process. A range of expressions is evident from these quotes: Feelings of empowerment, novelty, fright, pride, solidarity, anger, naivete, hope.

Empowerment, Pride and Social Consciousness

> I guess it makes me feel important and I feel useful in helping my people.
>
> B.Q.

> ...we really worked hard today, harder than before. I know that we accomplished just so many things that were important. I'm beginning to feel the pride of my work.
>
> W.S.

> We have understood that the Hispanic community needs a lot of economic help. The Americans do not care for the Hispanic people, so we ourselves have to help our classes. That's why I like this project, because I feel important knowing I can help the community.
>
> Y.N.

> I think that if we work with dedication and enthusiasm, we will obtain good results and we will all be very proud to know that our work has not been a failure.
>
> A.A.

> Yesterday we went to Florence Heights. We have seen many problems of our people. I noticed the presence of a feeling of oppression that seems to multiply by each day and can be seen in the relationships among family members.
>
> J.A.

New Experiences and Self Reflection

> Maybe this program will help me open my mind more to my

people's needs.

N.S.

Today we talked about interviewing skills. I think we all benefited for the interviews and for our lives because it is good to be a good listener.

B.A.

You have to be patient to work with our people. I think in the future I will be more mature and I will be able to work more seriously.

B.Q.

Working in a small group made me really understand the difference in people's mind.

N.S.

I learned that I shouldn't be afraid to talk and say what I want.

J.B.

Naivete and Being Scared

Yesterday was the day of the meeting...I was very scared but I asked questions and I wrote down what the people thought...I'm never going to forget yesterday for as long as I live.

J.R.

The first day of the questionnaire and I was nervous as hell.

W.S.

Frustration and Doubts

Our group has lost little by little its discipline...maybe our convictions are not strong enough or we can't confront our efforts nor see how we will help our community, because the results are not immediate...social change does not occur overmight...maybe we don't think our efforts are legitimate.

J.A.

The meeting disappointed me a little because we planned and expected more people from the community.

W.P.

> ...we went to...to interview a family and no one was there. I got very mad with the community, because we are trying to help the Spanish community and how are we going to help them if they don't give us their cooperation?
>
> J.R.

> I was very disappointed about one of our co-workers...he was supposed to be working with us. It is too bad that he is acting so irresponsible and seems he doesn't have a grasp on what it means to have social consciousness. I hope his attitude changes.
>
> B.Q.

> Some people said that some of the questions are kind of rude because of the information asked but I believe that if we act friendly enough we could establish a sense of trust where it will be easy to talk about these questions without creating any tension.
>
> B.Q.

From these excerpts we can appreciate some of the more subjective experiences of the participating youth. It is the opinion of the principal investigator that this project has had an impact, although difficult to measure, which can be evaluated as a positive growth experience for the involved youth. Additionally, the project has accomplished its principal objective, namely, to identify the mental health problems and needs of the Hispanic community under study. The importance of this for future program planning of human services can not be understated.

Finally, we must consider the relevance of the study's methodology to the development of participatory research practice. The conceptual basis of participatory research is grounded in the theory of praxis, as earlier stated. This theoretical orientation impels us to understand the profound dialectic between theory and practice. Concretely, this implies that methodologies informed by this conceptual approach are open for development and change, given the context and situation wherein

they are implemented. Furthur, the concept of participatory involvement stresses the collaborative engagement of people in the activities significant to their social lives. This implies that engaging in a participatory method towards solving their problems and needs can potentiate the developing of their capabilities and consciousness. The future of this method can only emerge from earlier attempts and projects. The present study is such an attempt and as such, is seen as contributing to the development of a participatory research practice.

Conclusions

It is the opinion of this investigator that this study has affirmed the following:

First, that participatory research holds a vision that can offer a viable alternative to the current research methodologies.

Second, that such a project can involve community youth given adequate and appropriate training.

Third, that this study has been able to identify mental health problems and needs, which will be useful in planning for human services.

Fourth, that the opportunity to defy conventional research practices and explore more meaningful methodologies for a people and for an investigator can be undertaken by researchers from an academic setting.

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APPENDIX A

Letter to the Community

Original Letter Sent to the Community

24 de Julio de 1979

Estimado (a) Sr. (a) Zavala:

Esta carta es para informarle a la comunidad que hemos formulado un questionario con el objetivo de poder identificar los problemas y necesidades de la comunidad hispana de Northampton y Florence. Este questionario sera llevado a la comunidad por un grupo de jovenes del Proyecto Latino. El Proyecto Latino es un programa de trabajo para jovenes organizado por las Casa Latina y el programa de CETA. Estos jovenes se dividiran en grupos de dos personas por casa para entrevistar a las familias ya que para conseguir la informacion que necesitamos, queremos trabajar directamente con la comunidad misma. Necesitamos su cooperacion. Este questionario sera la manera de apuntar las opiniones y sugerencias de la comunidad.

Nosotros estaremos llamando a su casa para poder hacer una cita sobre cuando podamos ir a su casa para llenar el questionario. Esta informacion es necesaria y valiosa ya que le permitira a la Casa Latina y a otras agencias planificar servicios y programas que tomen en cuenta esta informacion. Tambien dara a la comunidad hispana informacion concreta para luchar por mejores servicios y programas. Por ejemplo, cogeremos informacion sobre vivienda, salud, transportacion y otros asuntos.

La proxima semana vamos a comenzar las entrevistas. Esperamos tener exito, en este projecto con su participacion y cooperacion. Nosotros nos sentimos muy orgullosos pues estamos aprendiendo desde jovenes a tener conciencia social sobre las necesidades y problemas de nuestra comunidad.

Toda informacion que usted nos de en este questionario sera absolutamente confidencial y en ninguno de los questionarios se le pedira que se identifique por nombre. Asi velaremos y protejeremos la confidencialidad de sus opiniones y sugerencias. Agradecemos de antemano por su colaboracion tan valiosa.

Sinceramente:

Proyecto Latino

Translated Letter Sent to the Community

July 24, 1979

Dear Mr. or Mrs. _____:

This letter is to inform the community that a questionnaire to identify the problems and needs of the Hispanic community in Northampton and Florence has been prepared. This questionnaire will be taken to the community by a group of youths from the "Proyecto Latino." This project is a work program for youth organized by the Casa Latina and CETA. The youth will be divided into teams of two per household in order to interview each family and obtain necessary information. We need the cooperation of the community as this questionnaire is one way to note the opinions and suggestions of the community.

We will call your house to make an appointment with you as to when we can visit you to fill out the questionnaire. This is necessary and valuable information as it will allow the Casa Latina and other agencies to plan services and programs that respond to this information. Also, the Hispanic community will have concrete information in order to struggle for better services and programs. We will be obtaining information on housing, health, transportation and other matters.

Next week we will begin interviewing. We hope that with your participation and cooperation this project will succeed. We feel very proud because as youth we are learning to develop a social consciousness about the needs and problems of our community.

The information that you give us will be strictly confidential and in no questionnaire will you be asked to identify yourself. In this way we want to protect your confidentiality. We will appreciate your valuable cooperation.

Sincerely,

Proyecto Latino

APPENDIX B

Individual Evaluation Form

Individual Evaluation
Evaluacion Individual

1. Hice un trabajo bueno?
   Did I do a good job?

2. Puse todo mi esfuerzo?
   Did I put all my effort?

3. Como me lleve con el resto del grupo?
   How did I get along with the group?

4. Pienso que valio la pena todo el proceso?
   Was the whole process worthwhile?

   Porque si o porque no?
   Why if yes or if no?

5. Como me lleve con mi supervisor?
   How did I get along with my supervisor?

6. Como me lleve con la entrenadora?
   How did I get along with the trainer-facilitator?

7. Que pienso del grupo?
   What do I think about the group?

8. Cumpli mis metas y expectativas?
   Did my efforts meet my goals and expectations?

9. Que aprendi sobre mi mismo? Sobre trabajo en grupo? Sobre como yo trabajo en grupo? Sobre los companeros?
   What did I learn about myself? About work in groups? About how I work in groups? About my fellow group members?

10. Que aprendi que no sabia antes (enumere)?
    Did I learn something I didn't know before (list)?

11. Que fue lo mas significante que aprendi?
    What was the most important thing I learned?

12. Que fue la experencia mas frustrante?
    What was the most frustrating experience?

13. Que podia suceder para cambiar los problemas que hubieron?
    What could be done to change the problems that occurred?

14. Como me sentia al principio y como me siento ahora?
How did I feel at the beginning and how do I feel now?

15. Que piensas de la organizacion de Proyecto? De La Casa Latina? La comunidad?
What do you think of the organization of the project? Of Casa Latina? Of the community?

16. Cual quier otro comentario....
Any other comments....

APPENDIX C

Survey Instrument

#_____

Translation of Selected Items Relevant to Identifying Mental Health Needs and Problems

Questionario Para Identificar Las Necesidades de la comunidad Hispana en el condado de Hampshire

Survey to Identify the Needs of the Hispanic Community in Hampshire County

Sexo:
1 = Masculino 2 = Femenino
Sex Masculine Feminine
Lugar de Residencia -Place of Residency
1 = Florence Heights
2 = Hampton Gardens
3 = Hampshire Heights
4 = Meadow Brook
5 = casa alquilada en Northampton
6 = casa propia en Northampton
7 = casa alquilada en Florence
8 = casa propia en Florence
9 = Easthampton

Otro_____
(Other) ___

Nombre del Entrevistador_____
Name of Interviewer
Fecha de la Entrevista_____
Date of Interview
Hora empezo_____
Hour started
Hora termino_____
Hour finished

(INFORMACION GENERAL)
GENERAL INFORMATION

En esta parte le queremos hacer preguntas generales sobre su familia.

1. Cuantos hijos/as actualmente viven en su casa?

(2)_____(Escriba el numero desde 0-9)

Para cada niño favor de indicarnos su sexo y edad. Empieze con el mas pequeño.
(1 = Masculino 2 = Femenino)

		Sexo		edad (Escriba la edad)
Hijo/a #1	(3)	____	(4,5)	_____
Hijo/a #2	(6)	____	(7,8)	_____
Hijo/a #3	(9)	____	(10,11)	_____
Hijo/a #4	(12)	____	(13,14)	_____
Hijo/a #5	(15)	____	(16,17)	_____
Hijo/a #6	(18)	____	(19,20)	_____
Hijo/a #7	(21)	____	(22,23)	_____

(Si hay mas de 7 niños, escriba la información aquí)_____

_____

2. Cuantos años tiene usted? (24,25)_____
How old are you?
Y su esposo/a? (26,27)_____
(Escriba edad al lado; si no tiene esposo/a, anote "no aplica o N/A

3. Vive con usted algun otro familiar? (28)_____ (1 = si 2 = no)

Cuantos? (29)_____(Escriba el número si contestan que si)

Si hay alguna persona viviendo con usted de 55 años a más, favor de decirnos su edad. (30,31)_____

(32,33)_____

4. Favor de describirme su estado civil. Es usted: (Circule el que indiquen) Please describe your marital status.

1=soltero/a single
2=casado formal married
3=casado informal (viviendo juntos) consensual union
4=separado/a separated
5=divorciada/o divorced
6=viuda/o widowed
7=soltero/a y jefe de familia single head of household

(106____ (of third code sheet)

5. Endonde nació usted? (34)_____
Where were you born?
Su esposo/a (35)_____
(Use el número que corresponde de la clave pero no lea la lista)

1=Puerto Rico
2=Nueva York
3=Mass.
4= Otro estado en los Estados Unidos
5=Pais Latino americano_____ Another state
6=Otro_____ a Latin American country
other

6. En donde nacieron sus hijos? (Ponga al lado del lugar el número de niños que nacieron ahí. Use desde 0 hasta 9 y 9 es si nacieron más de 9 en un lugar)

Puerto Rico (36)_____
Nueva York (37)_____
Mass. (38)_____
Otro Estado (39)_____
Pais Latino americano (40)_____
Otro lugar (41)_____
(Escriba el pais)

7. Cuanto tiempo lleva su familia en:
How long has your family been:
Los Estados Unidos (42,43)_____
In the United States
En Massachusetts (44,45)_____ In Massachusetts
el Condado de
Hampshire (46,47)_____ (escriba el numero de años o meses)
In Hamsphire County

8. Cuanto tiempo vive usted aquí? (48,49)_____
(escriba el año y si ha vivido menos de un año, escriba el número de meses 2 años o 2 meses, etc.)

9. Porqué razón se mudó usted para este condado? (Deje que la persona le diga y entonces escoja la alternativa mas apropiada. Leasela para confirmar).

1=porque mi familia vivía ya aqui

2=porque no tenía ni encontraba trabajo endonde estaba antes.

3=porque en donde vivia habían muchos problemas en el vecindario y quería mejor vida para la familia.

4=porque había oido de familiares o otras personas que aca se vivía bien.

5=porque no sabía a donde ir y me daba lo mismo.

6=porque mi esposo o esposa encontró trabajo.

7=porque las cuidades grandes no me gustan.

8=Otro_____

(50)___

10. Que idioma habla usted en su casa? What language do you speak at home?
(51)____

0 = solo español Only Spanish

2 = mucho español y un poco de inglés Mostly Spanish and a little English

3 = mitad español y midad en inglés Half Spanish and half English

4 = mucho inglés Mostly English

5 = solo inglés Only English

6 = otro_____

(VIVIENDA)

En esta parte queremos preguntarle sobre aspectos de su vivienda y su vecindario.

11. En cuanto a los servicios de mantenimiento, como describiría usted los siguientes servicios.
Primero escuche a esta clave y luego le leo la lista: Dirá usted que:

0 = no dan el servicio.

1 = si dan y muy bueno.

2 = si dan servicio mas o menos bueno.

3 = si dan servicio pero no muy bueno,

4 = si dan pero irregularmente.

5 = si dan pero malo.

6 = si dan pero muy malo.

7 = no se porque no me ha pasado.

Ahora para cada uno de estos digame:

(52)___Pintan la casa o el apartamento.

(53)___Arreglan la plomeria.

(54)___Arreglan problemas de electricidad.

(55)___Mantiene los alrededores limpios.

(56)___Limpian la nieve en el invierno.

(57)___Dan buena calefacción.

(58)___Riegan sal en la carretera durante el invierno.

(59)___Reparan puertas, ventanas, rotos en la pared, etc.

(60)___Recogen la basura regularmente.

(61)___Alumbrado público.

___Otros_____

12. Cree usted que hacen falta las siguientes necesidades o facilidades? (Lea la lista y ponga el número apropiado en cada blanco) (1 = si 2 = no 3 = no se)

(62) ___Lavadoras y secadoras públicas

(63) ___Teléfonos públicos

(64) ___Interpretes en la Autoridad de Vivienda

(65) ___Supermercados o bodegas cerca

(66) ___Supermercados o bodegas que vendan productos hispanos

(67) ___Que los inquilinos conocan sus derechos

(68) ___Que los vecinos organicen una asociación de inquilinos

13. Cuan a menudo hay peleas entre vecinos, adolescentes o niños? (Deje que diga y confirme con las alternativas escritas. Circule la que corresponde)

(69) ____1 = nunca 2 = muy pocas veces 3 = algunas veces
4 = casi siempre 5 = todo el tiempo

14. Cuan a menudo hay problemas de vandalismo en su vecindad? (Deje que diga y confirme con las alternativas escritas. Circule la que corresponde)

(70) ____1 = nunca 2 = muy pocas veces 3 = algunas veces
4 = casi siempre 5 = todo el tiempo

Ahora en cuanto a transportación

15. Con que frecuencia usa usted o su familia los siguientes medios de transportación. (Deja que le diga y confirme leyendole la clave)

(71) ___guagua pública

(72) ___taxi

(73) ___servicios de transportes de agencias sociales

(74) ___carro privado

(75) ___carro prestado

(76) ___motora

(77) ___bicicleta

(78) ___voy a pie

1 = nunca

2 = muy pocas

3 = algunas veces

4 = muchas veces

5 = todo el tiempo

6= solo uso ese medio

16. Que problemas confronta usted con la transportación? (Permita que la persona conteste y circule todos que digan)
(79)
1 = No hay guaguas cerca a donde vivo

2 = La guagua es cara

3 = Los taxi cobran demasiado dinero

4 = No tengo carro

5 = Otro_____

17. En cuanto a la recreación en su vecindario, cuales de estas actividades considera usted que se necesitan: (lea la lista y escriba # apropiado en cada blanco)
(1 = si 2 = no 3 = no se)

(80)___parque para niños (81)___bailes

(82)___centro de recreación (83)___deportes

(84)___gimnasio (85)___clubes sociales

(86)___actividades al aire libre ___Otro

18. De la siguiente lista de actividades, señale la que le gusta más:
(lea lista y circule la que escoja)
(87)___
0 = ir al cine 6 = Bingo, domino, cartas o barajas

1 = leer 7 = veo televisión

2 = bailes 8 = hablo con amigos/as

3 = pasadias 9 = otro_____

4 = clubes sociales

5 = deportes

(EDUCACION)
EDUCATION

En esta parte queremos preguntarle sobre asuntos relacionados con la escuela de sus ninos y los intereses educativos que usted tenga.

(INFORMACION GENERAL)
General Information

19. Hasta que grado estudió usted? Up to what grade did you study?
(88)___
(No lea la lista, deje que conteste y circule el número que corresponde. Si tiene que aclarar o tiene dudas, lea la alternativa)

0 = Ninguno None

1 = 1 - 5

2 = 6 - 8

3 = 9 - 11

4 = Se graduó de escuela superior Graduated from High School

5 = Estudió en una escuela vocacional o tecnica Studied at a vocational or technical school

6 = Algunos años de universidad Some years of university

7 = Se graduó de universidad Graduated from college

8 = Estudios graduados o profesionales Professional or graduate studies

9 = Otro Other _____

20. Por que razón dejó de estudiar?
(89) ___
(deje que conteste primero y solo lea las alternativas si quiere aclarar o tiene dudas, solo circule uno)

0 = problemas emocionales

1 = responsabilidades familiares

2 = dificultades financieras

3 = problemas de salud

4 = matrimonio

5 = por estar en cinta

6 = por falta de interes

7 = por que no estaba pasando el curso

8 = porque sentia que lo que ensenaban era irrelevante o lo ponian en forma incorrecta, injusta

9 = Otro

21. En que idioma hablan sus niños mas a menudo en la casa? (Lea las alternativas solo para aclarar lo que diga, circule solo una)
(90) ___

0 = solo español

1 = mucho español y un poco de inglés

2 = poco español y mucho inglés

3 = mitad español y mitad en inglés

4 = mucho inglés

5 = solo inglés

6 = otro _____

(Adultos)

22. Cuanto inglés entiende usted?
(91)___
(deje que conteste, confirme con la que es apropiada y circule el #)

0 = no entiendo nada
1 = entiendo muy poco
2 = entiendo algo, me defiendo
3 = entiendo bastante
4 = entiendo todo

23. Cuanto inglés habla usted (vea instrucciones para la #23)
(92)___
0 = no hablo nada
1 = hablo muy poco
2 = hablo algo, me defiendo
3 = hablo bastante
4 = hablo perfectamente

24. Si le gustaría estudiar hoy en dia, cuales de estos le gustaria estudiar: (lea la lista y pida que conteste según la clave)

1 = si 2 = no 3 = no se 4 = no aplica

(93)___a.___inglés

(94)___b.___español (mejorarlo)

(95)___c.___a leer y a escribir

(96)___d.___historia y cultura de Puerto Rico

(97)___e.___entender sobre los problemas sociales y politicos

(98)___f.___estudiar en alguna escuela vocacional (mecanica, carpinteria, secretariado. etc)

(99)___g.___estudiar para el G.E.D. (diploma de Escuela Superior)

(100)___h.___estudiar para alguna profesión (enfermería, abogacia, doctor, maestra)

(101)___i.___estudiar para trabajo en servicio a la comunidad.

___Otro_____

25. De esta lista, cual seria su prioridad?_____
(102)___
(Escriba la letra en el blanco: ejemplo, a por inglés)

26. Si ha querido estudiar aque, por qué razón o razones no ha podido?
(103)___
(deje que le diga y circule todas que se digan; confirme o lea una alternativa si necesario)

0 = no hay centros donde estudiar lo que me interesa

1 = hay centros pero enseñan en inglés y no comprendo

2 = no tengo dinero para pagar los cursos

3 = no tengo quien cuide mis niños

4 = no tengo transportación

5 = tengo que trabajar

6 = tengo miedo de fracasar

7 = otro_____

27. Conoce usted los siguientes centros de estudio? (lea la lista y pida que diga si no)

1 = si 2 = no

(104)___El Gallo

(105)___Smith Vocational

(106)___Skills Center

(107)___Servicios de Extension

(108)___Continuing Education, UMASS

(109)___Universidad de Mass.

(110)___Greenfield Community College

(111)___Holyoke Community College

(112)___Hawley Jr. High High School (G.E.D.)

(NIÑOS Y JOVENES)

28. Cuantos niños de edad escolar (desde Kinder a High School) van a la escuela en su familia? (circule el # que digan)
(113)___

9 = 9 o más

29. Cuantos niños de edad escolar no van a la escuela?_____(sencillamente escriba el numero que le degan)
(114)___

30. A cual escuela va su(s) niño/a? (ponga el número de niños que estan en las diferentes escuelas, o hasta 9)
(115)___

	Número en esa escuela
Leed Elementary School	1 _____
Jackson Street School	2_____
Ryan Road School	3_____
Florence Grammer School	4_____
Bridge School	5_____
Hawlwy J. High School	6_____
Kennedy School	7_____
Northampton High School	8_____
Smith Vocational School	9_____
Job Corps, Chicopee	10_____
University of Mass.	11_____
Greenfield Community	12_____
Holyoke Community Coll.	13_____
Otro_____	14_____

31. Cuantos niños estan en el programa bilingue?
(116)___
9 = 9 0 mas

32. Si su niño (a) no esta en la escuela pero debería estar, por cuales razones no va? (deje que la persona conteste y solo aclare leyendole las que se parecen a lo que dijo - circule todas que diga, pero pregunte por la mas importante y subrayela)
(117)___

0 = no le interesa la escuela

1 = no hay transportación escolar

2 = tiene problemas aprendiendo

3 = crea problemas en la escuela

4 = no quiero que vaya

5 = porque la escuela no le enseña nada

6 = porque necesito que me ayude en la casa

7 = Otro_____

33. Ha tenido su hijo/a alguno de estos problemas en la escuela? (lee cada uno y anote el # correspondiente)
1 = si 2 = no 3 = no se 4 = no aplica

(1)___problemas con los maestros

(2)___problemas con los demas estudiantes

(3)___por vandalismo

(4)___por no hacer su trabajo

(5)___corta clase

(6)___se distrae y no atiende al maestro

(7)___por problemas con drogas

(8)___por faltar mucho a la escuela

34. Según su experiencia con la escuela de sus hijos, cuales de los siguientes puntos cree usted necesario para mejorar la enseñanza y el aprendizaje de sus hijos? Diga si, si los cree necesarios; no, si no los cree necesarios; no sabe o no aplica.
1 = si 2 = no 3 = no se 4 = no aplica

(9)___maestros bilingues hispanos

(10)___consejeros hispanos

(11)___maestros que respetan al hispano

(12)___ayuda especial para niños con problemas en el aprendizaje, emocionales. fisicos, etc.

(13)___una mejor organizacion de padres hispanos

(14)___mejor nutricion en la escuela

(15)___programas de trabajo y estudio en la esculea superior

(16)___evaluaciones psicologicas y de capacidad hecha por hispanos preparados en esta area

(17)___mejor transportacion escolar

(18)___curriculo de estudios adecuado a niños hispanos

___otro_____

35. Pertenece usted o su esposo/a al PAC?
Asociación de padres hispanos)
(19)___
1 = si 2 = no 3 = no se 4 = no aplica

(20)___

36. Sabe usted que niños que tienen cualquier problema en el aprendizaje, sea por razones físicas, emocionales, etc., tienen el derecho a un programa educativo especial?
1 = si 2 = no

Conoce usted la ley llamada Capitulo 766?
1 = si .2 = no

(21)___

37. Quiere usta saber más sobre el programa bilingue, la ley 766, la evaluacion de niños en la escuela o cualquier otro aspecto sobre la ensenanza que le concierne?
1 = si 2 = no

(SITUACION ECONOMICA)
ECONOMIC STITUATION

En esta parte le queremos hacer preguntas sobre su situación económica. Here we would like to ask you about your economic situation.

38. Que clase de ingresos recibe usted o miembros de su familia? (circule las que apliquen; escribe el ingreso según el periodo que le digan y escriba quien lo recive)

(22,23,24) What sources of income does your family have?	Semanal $weekly	cada dos semanas $every 2 wks.	mensual $monthly	anual $yearly	quien who
a. Salaria por trabajo Salary (25,26,27)					
b. Welfare (categoria si la conoce) Welfare (28,29,30)	___	$_____	___	___	___
c. Seguro Social Social Security (31,32,33)	___	_____	$_____	___	___
d. Beneficio por veteranos Veterans benefits (34,35,36)	___	_____	___	___	___
e. Desempleo Unemployment (37,38,39,)	$_____	_____	___	___	___
f. Beneficios a niños Child support payments (40,41,42)	___	_____	___	___	___
g. Food Stamps Food Stamps (43,44,45)	___	_____	$_____	___	___

h. Su ingreso total anua Total Income incluyendo todo benificio welfare, SSI, salario etc. (46,47,48,49,50)
$_____Por año

(51)____

39. Incluyendose a ud. , cuantas personas viven de este ingreso?_____
(escriba el # de personas desde o hasta 9 y 9 implica 9 o más)

(Esta parte es solo para los que trabajan, si no trabaja pase a la pregunta ____# 46)

40. Que tipo de trabajo hace usted?
(escriba lo que la persona describe)

Usted_____

Esposo/a_____

Otra persona en la familia_____

41. Cuanto tiempo lleva trabajando ahí?
(escriba los años o los meses)

Usted_____

Esposo?a_____

Otra persona en la familia_____

42. Que beneficios le ofrecen en su trabajo?
(lea clave y lista)
1 = si 2 = no

(52)___Vacaciones pagadas (53)___Compensacion por maternidad

(54)___Seguro de salud (55)___Tiempo por trabajo compensatorio

(56)___Compensación de trabajo (57)___Bonos

(58)___Pago horas extras ___Otros

43. Pertenece a una union relacionada con su trabajo?
(lea clave y lista)
1 = si 2 = no

Usted(59)___ Otra persona en la familia (60)___

Esposo/a(61)___

44. Con que paga su comida?
(circule todas los que le diga)

(62)___

1 = Food Stamps

2 = Dinero

3 = Crédito

45. Tiene Ud. o su familia un Huerto?
1 = si 2 = no
(63)

46. Durante el último año se ha encontrado usted o su familia amenazada por las siguientes situaciones por falta de pago? (lea la lista)
1 = si 2 = no 3 = no aplica

(64)___Corte de luz (65)___Corte de teléfono

(66)___Corte del gas (67)___Negado servicios médico

(68)___Corte de la calefacción ___Otro_____

(69)___Aviso de desahucio (botarlo de apartamento)

47. Si necesitara dinero en caso de una emergencia (muerte, fuego, enfermedad, etc), como lo conseguiria? (deje que la persona diga primero y lea los alternativas para aclarar. Circule uno)

(70)

0 = usaría los ahorros de la familia

1 = tengo seguro

2 = tengo crédito

3 = cogería prestado de un amigo familiar

4 = no sabria que hacer

5 = otro

48. Como usted ve la situación económica de su familia? (lea la clave y escoja uno) How would you describe your economic situation?
(71)____

1 = muy buena very good 3 = regular fair 5 = mala bad

2 = buena good 4 - no muy buena not very good

(ASUNTOS DE LA FAMILIA)

FAMILY MATTERS

En esta parte le hacemos preguntas sobre asuntos que conciernen a muchas familias para identificar servicios que necesitan.

49. Cuales de los siguientes problemas dira usted que existen en su communidad? Which of the following problems would you say exist in your community? Primero le voy a leer una clave y despues la lista de situaciones a ver que usted cree:
First I will read a key and then the situations.

0 = nunca never
1 = muy pocas veces very few times
2 = algunas veces sometimes
3 = muchas veces often
4 = todo el tiempo all the time
5 = no se don't know

(72) ___abuso de niños o maltrato de niños por parte de los padres
Child abuse or bad treatment of children by parents

(73) ___malos ejemplos de parte de los padres
Parents who provide poor examples

(74) ___niños que dominan a sus padres
Children who dominate their parents

(75) ___esposos que maltratan a sus esposas
Husbands who abuse or mistreat their wives?

(76) ___esposas que maltratan a sus esposos
Wives who mistreat their husbands?

(77) ___vandalismo y delincuencia en la comunidad por miembros de la comunidad Vandalism and delinquency by community members

(78) ___vandalismo y delincuencia en la comunidad por gente que no son de la comunidad Vandalism and delinquency by non community members

(79) ___niños con comportamiento agresivo.
Aggressive children

(80) ___uso de drogas
Use of drugs

(81) ___uso excesivo de alcohol
Excessive use of alcohol

___otro ___
Other

50. Esta es una lista de razones que pueden crear problemas en el hogar para muchas familias. nos puede decir con que frecuencia cree usted que suceden en su comunidad? The following are some of the reasons that can cause problems in families. Can you tell us with what frequency they exist in your community?
(lea clara y lista)

0 = nunca never
1 = algunas veces sometimes
2 = muy pocas veces very few times
3 = muchas veces often
4 = todo el tiempo all the time
5 = no se don't know
6 = no quiso contestar would not answer
7 = no aplica does not apply

(82) ___Disciplina por parte de los padres demasiado fuerte
Harsh discipline by the parents

(83) ___falta de disciplina
Lack of discipline

(84) ___poca atención de parte de los padres para con sus hijos
Lack of attention from the parents towards their children

(85) ___inabilidad de los padres comprender a sus hijos
Lack of understanding between parents and children

(86) ___frustraciones económicas que causan tensión en la familia
Economic frustrations that cause tension in the family

(87) ___por divorcio
Because of divorce

(88) ___Abuso del alcohol por algun miembro de la familia.
Alcohol abuse by a member of the family

(89) ___por el uso de drogas por algun miembro de la familia
Drug use by a member of the family

(90) ___por algún problema emocional de algún miembro de la familia
Emotional problem of a member of the family

___Otro ___
Other

51. Según las problemas que su familia ha tenido, estaría usted interesada en asistir a alguno de estas actividades educativas:
(lea clave y lista) According to the difficulties your family has experienced, would you be interested in assisting any of the following educational workshops?

1 = si yes
2 = no no
3 = no se don't know
4 = no contesto no answer
5 = no aplica does not apply

(91)___taller sobre los problemas en la crianza de niños
Workshop about child rearing problems
(92)___taller sobre problemas con adolescentes
Workshop about problems with adolescents
(93)___taller sobre mejorar el entendimiento entre esposos y esposas
Workshops about improving husband-wife relationship
(94)___taller para madres solas
Workshops for single mothers
(94)___taller para rehabilitacion de jovenes con historial de abuso de drogasWorkshops for rehabilitation of young drug abusers
(96)___taller sobre alcoholismo
Workshops about alcoholism
(97)___taller sobre como mejorar las relaciones familiares
Workshops about improving family relations
(98)___taller para jovenes para mejorar su vida familiar
Workshops for youth about improving their family life
(99)___taller sobre los problemas emocionales
Workshops about emotional problems
(100)___taller para desarrollar destresas de sobrevivencia en este sistema
Workshops to develop survival skills
(101)___taller sobre la realidad social y economica que nos confronta y su impacto en la familia
Workshops about the social and economic reality and how it impacts on the family
___Otro
Other

52. Necesita su familia alguno de estos servicios?
(lea clave y lista)

1 = si
2 = no
3 = quizas
4 = no se
5 = no contesto

(102)___Centro de cuidado de niños en su propio vecindario

(103)___Transportación para que su niño asista a un centro de cuidado de niños

(104)___Ayuda con el cuidado de un anciano en la familia

(105)___Ayuda con tareas de la casa

(106)___Ayuda con las tareas escolares de los ni..os.

(107)___Ayuda con miembro incapacitado en la familia (ciego, sordo, paralítico, etc.)

(108)___Ayuda con niño o familiar con desarollo limitado

___Otro_____

53. Tiene usted conocimiento de los siguientes servicios a la comunidad? (lea clave y lista)

Do you know any of the following service oriented agencies in the community?

0 = no 1 = he oido mencionar 2 = si 3 = he usado servicios
4 = no contesto have heard of yes have used their services
did not answer

(1)___Alcoholic Prevention Program

(2)___Amherst Medical Associates

(3)___Amherst Survival Center

(4)___Children's Aid and Family Service

(5)___Casa Latina

(6)___División of Employment Security

(7)___Family Planning Council of Western Mass.

(8)___Franklin Hampshire County Community Mental Health Center

(9)___Group Day Care and Family Day Care

(10)___Headstart

(11)___Help for Children

(12)___Networks

(13)___Northampton Visiting Nurse Assoc.

(14)___Threshold

(15)___Western Mass. Legal Services

(16)___Youth Employment Service

(17)___New England Farmworkers Council

(18)___El Gallo

(19)___H.C.A.C.

(20)___Community Self-Reliance (Canning Center)

(JUSTICIA)

En esta parte queremos saber sobre su experiencia con aspectos del sistema judicial en esta area.

54. Segun su experiencia o la de su familia, cuales de los siguientes prejucios cree usted que tiene la policia sea de Northampton o de Florence? Indique si o no. (lea clave y lista)

1 = si 2 = no 3 = no se 4 = no contesto

(21) ___racial

(22) ___de clase (contra de los pobres, a favor de los ricos, etc.)

(23) ___cultural

(24) ___idioma

(25) ___religión

___otro_____

55. Cuales de los siguientes servicios como parte del sistema judicial cree usted que la comunidad Hispana necesita?
1 = si hace falta 2 = no hace falta 3 = no se 4 = no contesto
5 = no aplica

(26) ___Empleados hispanos en servicios legales

(27) ___Servicio legal para la juventud

(28) ___Ayuda en contra de la brutalidad policiaca

(29) ___Ayuda en contro del abuso de mujeres hispanas

(30) ___taller sobre los derechos legales en general en español

(31) ___Interpretes en las cortes o en la estación de policia

(32) ___Policias bilingues

(33) ___Abogados bilingues o personal para-legal bilingue

___Otro_____

56. Ha tenido usted o algun miembro de su familia alguna experiencia de prejucio y/o discriminación en estos lugares durante el tiempo que ha vivido en este condado?
(lea la clave y la lista)
1 = si 2 = no 3 = no se 4 = no aplica

(34) ___en el trabajo

(35) ___en la tienda

(36) ___en la vivienda

(37) ___con los doctores privados

(38) ___en la escuela

(39) ___en welfare

(40) ___en el hospital

(41) ___en seguro social

(42) ___en la corte

(43) ___en el desempleo

(44) ___en la guagua

___Otro_____

57. Esta usted o su esposo/esposa registrado para votar en el Estado de Mass?
(llene cada blanco sequn apropiado)
1 = si 2 = no 3 = no aplica

Entrevistado(45)_____

Esposo/A(46)____

Otro adulto en la familia (47)____

(SALUD)

En esta parte le queremos hacer preguntas sobre su salud y la de su familia. Favor de contestar lo mejor que pueda.

58. Que tipo de seguro médico o plan médico tiene usted?_____
(lea la lista)

0 = Ninguno ud.(48)____

1 = Medicaid Su esposo/a (49)____

2 = Medicare Hijos (50)_____

3 = HIP (Health Insurance Plan)

4 = Blue Shield/Blue Cross

5 = Valley Health Plan

6 = Student Health Plan

7 = Veteranos

8 = Otro_____

59. Le voy a leer una lista de areas generales de problemas médicos y quisiera que me indicara quien padece de ese problema.
(51)____

0 = Nadie 1 = Udted 2 = esposo 3 = Hijo 5 = Mas de un hijo o hija
6 = Esposo y esposa 7 = otro familiar 8 = Tres o mas personas.

Problemas relacionados con alcohol (52)___

Artritis o reumatismo(53)___

Cáncer(54)___

Problemas de Salud Dental(55)___

Diabetis (56)___

Problemas del sistema digestivo(úlceras, apendicitis, colitis, infecciones del higado)(57)___

Abuso de drogas(58)___

Problemas de la vista, oido, garganta (59)___

Problemas del corazón o circulatorios (alta presión. dolores en el pecho, venas varicosas (60)

Problemas de salud mental(61)___

Problemas respiratorios____(asma, tos, tuberculosis) (62)___

Problemas de la piel(63)___

Incapacidad fisica(64)___ (especifique cual)_____

Alergias(65)___

Otro_____

60. En donde recibe usted o algún miembro de su familia tratamiento medico? (anote el lugar que acude con mas frecuencia)
(66)____

0 = Ningún Lugar_____

1 = Cooley Dickinson Hospital

2 = Clínica en Amherst (Amherst Medical Associates)

3 = Florence Medical Center_____

4 = Doctor privado_____

5 = UMass Student Health_____

6 = Hospital de Veteranos en Northampton_____

7 = Hospital en Springfield (escriba cual_____

8 = Doctor privado y hospital público o privado_____

9 = Otro_____

61. Cuando usted solicitó tratamiento o asistencia médica en los lugares que indicó, encontró usted algunas de estas situaciones?
(lea lista y clave)
1 = nunca 2 = muy pocas veces 3 = algunas veces 4 = muchas veces
5 = todo el tiempo 6 = no aplica

(67)___falta de interprete

(69)___falta de dinero para pagar

(71)___no le atendieron por falta de seguro médico

(73)___sintió que no le atendieron debidamente

(68)___nadie le explicó nada sobre su condición

(70)___que no pudo ir por falta de transportación

(72)___que no pudo ir por falta de cuidado de sus niños

___otro_____

62. En general como describiría usted el servicio y la atención médica que le han dado en el lugar que mas frecuenta? (lea clave y escoga uno)
(74)___
0 = no se 1 = inadecuado 2 = regular 3 = adecuado 4 = muy bueno

63. Conoce usted la ley Hill-Burton? 1 = si 2 = no
(75)___

64. Conoce usted el Medical Bank de H.C.A.C.? 1 = si 2 = no
(76)___

Estaría usted o algun miembro de la familia necesitado o interesado en información sobre lo siguiente: (lea lista y clave)
1 = si 2 = no 3 = no se

(77)___Control sobre la natalidad

(78)___Los derechos que usted tiene en cuanto el servicio médico

(79)___Las enfermedades venereas

(81)___Problemas médicos particular a la mujer

(80)___Terapia física

(83)___La nutrición

(82)___Examen físico para los ninos o adultos

___Otro_____

(84)___Facilidades de emergencia

(SALUD MENTAL)
MENTAL HEALTH

En esta parte le preguntamos sobre problemas que a veces interfieren con las actividades de la vida diaria y con nuestro bienestar emocional. El propósito de estas preguntas que le pueden parece muy personal, es para ver las necesidades que existen en esta area y los servicios de las agencias de servicios humanos que urgen. Si no quiere contestar alguna pregunta, sera respetada su posición.

65. Cuando usted o algún miembro de la familia tiene alguna dificultad emocional, a quien usualmente prefiere ir a consultar?
(deje que la persona diga primero y circule el # que corresponde), si tiene que aclarar lea la alternativa apropiada)

When you or someone in your family has an emotional difficutly, to whom do you prefer to go to?

0 = nadie
no one

1 = otra persona en la familia
another family member

2 = a un amigo o amiga intima
to an intimate friend

3 = a otra persona en la comunidad
to someone in the community

4 = al cura o al pastor de la iglesia
to the priest

5 = a un(a) expiritista
to a spiritualist

6 = a un consejero
to a counselor

7 = a una trabajadora social
to a social worker

8 = a un psicólogo
to a psychologist

9 = a un psiquiatra
to a psychiatrist

66. Cuales seran sus primeras dos preferencias? Which would be your first two choices?
(deje que responda pero si necesario lea la lista de #65 y anote en los blancos los números en orden de preferencia_

lero( )___ 1st
2ndo( )___ 2nd

Si usted pudiese, diseñar servicios de consejeria para la comunidad hispana en este condado, según sus conocimientos de los problemas que afectan la comunidad: con cuales dos problemas empezaría?
(deje que la persona diga lo que quiera y escribalo en los blancos).

If you could design counseling services for your community, and according to the problems that you think exist in the community, what two services would you organize first?

67. Y si pudiese emplear ciertos tipos de personas que brindan este servicio, cuales cree usted serían de más confianza para los hispanos?
If you could hire certain people to staff these services, who would you prefer to hire?

a. _____

b. _____

c. _____

(Deje que diga: si dice no se, escriba esto mismo.)

68. Ha usado usted durante el último año algún servicio de salud mental? Have you used any mental health services within the last year?
1 = si yes 2 = no no 3 = no contestó did not answer
(84) ___

69. Si los hay usado. usted que: If you did use any, did you think that they were:
(85) ___

1 = fue una pérdida de tiempo a waste of time
2 = aprovecho regularmente la consulta useful
3 = logro resolver su problema helped solve your problem
4 = le fue de gran provecho greatly useful

70. Aqui hay una lista de situaciones emocionales que uno puede sentir en momentos dados de nuestra vida. Here is a list of emotional situation that we can experience at different times of our lives. Have you experienced these in the last year?
71. Las ha padecido usted en el último año?

0 = nunca never 1 = pocas veces few times 2 = algunas veces sometimes 3 = muchas veces often

(86) ___ No duerme bien de noche does not sleep well at night
(87) ___ Con dolores de cabeza Has headaches
(88) ___ Se siente nerviosa y tensa feels nervous and tense
(89) ___ Con dolores en el pecho, la espalda, o el estomago
(90) ___ Se siente deprimida feels depressed
(91) ___ Con ganas de gritar y darle a la pared o a alguien
* (92) ___ Se siente con mucha energia pero no sabe que hacer
(94) ___ Como que no puede soportar más su situación
* (93) ___ Con ganas de salir por la puerta y seguir andando
(95) ___ Aburrida con la vida feels bored with life
(96) ___ Con ganas de llorar y tirarse al piso
(97) ___ Se le olvidan las cosas
(98) ___ Siente que alguien la llama o toca la puerta, o esta detras de usted con ganas de hacerse algua daño

*92 feels a lot of energy but does not know what to do
93 feels like walking out the door and keep on going

Has any one in your family experienced any of these?
72. Ha padecido algun miembro de su famila de estas situaciones?
1 = si yes 3 = no se don't know
2 = no 4 = no contesto (99) ___ did not answer

73. Esta usted tomando algún medicamento para los nervios?
1 = si yes 2 = no 3 = no contesto did not answer
Do you take any medication for your "nerves"?

(100) ___

ADDENDUM TO QUESTIONNAIRE ITEM 71

71. Here is a list of emotional situations that we can experience at different times of our lives. Have you experiences these in the last year?

0 = never 1 = few times 2 = sometimes 3 = often 4 = all the time

Does not sleep well at night
Has headaches
Feels nervous and tense
Has chest, back or stomach pains
Feels depressed
Feels like yelling, crying, or hitting the wall or someone
Feels a lot of energy but does not know what to do
Feels like walking out the door and keep on going
Feels like can't stand his/her situation
Feels bored with life
Feels like crying and throwing oneself on the floor
Forgets things
Hears someone calling or knocking on the door...

APPENDIX D

Individual Tables Per Demographic Variables

1. Mental Health Problems
2. Family Problems
3. Community Problems

Percentage of Respondents Reporting Three Levels of Problem Frequency by Marital Status: Mental Health Problems

MENTAL HEALTH PROBLEM VARIABLES	MARITAL STATUS						p <
	Single (N=27)			Married (N=37)			
	Never	Sometimes	Often	Never	Sometimes	Often	
1. Can not sleep well at night	48.1	37.0	14.8	37.8	37.8	13.2	NS
2. Headaches	37.0	40.7	22.2	27.0	45.9	27.0	NS
3. Feels nervous and tense	23.1	38.5	38.5	32.4	51.4	16.2	NS
4. Has chest, back or stomach pain	53.8	34.6	11.5	51.4	35.1	13.5	NS
5. Feels depressed	33.3	40.7	25.9	35.1	48.6	16.2	NS
6. Wants to yell, hit the wall or someone	44.4	33.3	22.2	56.8	24.3	18.9	NS
7. Has much energy but doesn't know what to do	33.3	37.0	29.6	27.0	48.6	24.3	NS
8. Feels like walking out the door and keep on going	35.9	37.0	37.0	29.7	43.2	27.0	NS
9. Can't stand this situation	33.3	44.4	22.2	51.4	32.4	16.2	NS
10. Bored with life	37.0	29.6	33.3	54.1	32.4	13.5	NS
11. Feels like crying, throwing oneself on the floor	55.6	29.6	14.8	62.2	29.7	8.1	NS
12. Forgets things	29.6	48.1	22.2	37.8	25.9	16.2	NS
13. Feels like someone calls him/her or knocks at the door	77.8	18.5	3.7	75.7	13.5	10.8	NS

Percentage of Respondents Reporting Three Levels of Problem Frequency by Sex: Mental Health Problems

MENTAL HEALTH PROBLEM VARIABLES	SEX						p <
	Male (N=17)			Female (N=48)			
	Never	Sometimes	Often	Never	Sometimes	Often	
1. Can not sleep at night	35.3	41.2	23.5	45.8	35.4	18.8	NS
2. Headaches	35.3	64.7	0	29.2	37.5	33.3	.0192
3. Feels nervous and tense	17.6	64.7	17.6	31.9	40.4	27.7	NS
4. Has chest, back or stomach pain	47.1	47.1	5.9	53.3	29.8	14.9	NS
5. Feels depressed	41.2	52.9	5.9	33.3	41.7	25.0	NS
6. Wants to yell, hit the wall or someone	35.3	47.1	17.6	58.3	20.8	20.8	NS
7. Has much energy but doesn't know what to do	23.5	47.1	29.4	31.3	43.8	25.0	NS
8. Feels like walking out and keep on going	29.4	47.1	23.5	29.2	37.5	33.3	NS
9. Can't stand this situation	41.2	35.3	23.5	45.8	37.5	16.7	NS
10. Bored with life	52.9	23.5	23.5	45.8	33.3	20.8	NS
11. Feels like crying, throwing oneself on the floor	64.7	23.5	11.8	58.3	31.3	10.4	NS
12. Forgets things	29.4	41.2	29.4	35.4	50.0	14.6	NS
13. Feels like someone calls him/her ,or knocks at the door	76.5	17.6	5.9	77.1	14.6	8.3	NS

Percentage of Respondents Reporting Three Levels of Problem Frequency by Residence: Mental Health Problems

Mental Health Problem	RESIDENCE									
	Florence Heights (N=16)			Hampton Gardens (N=34)			Town (N=15)			
	Never	Some-times	Often	Never	Some-times	Often	Never	Some-times	Often	p <
1. Can not sleep at night	31.3	37.5	31.3	38.2	44.1	17.6	66.7	20.0	13.3	NS
2. Headaches	31.3	43.8	25.0	14.7	52.9	32.4	66.7	26.7	6.7	.0089
3. Feels nervous and tense	18.8	43.8	37.5	26.5	50.0	23.5	42.9	42.9	14.3	NS
4. Has chest, back pain	43.8	37.5	18.8	42.4	42.4	15.2	86.7	13.3	0	.0537
5. Feels depressed	12.5	43.8	43.8	38.2	47.1	14.7	53.3	40.0	6.7	.0364
6. Wants to yell, hit the wall or someone	31.3	25.0	43.8	64.7	23.5	11.8	46.7	40.0	13.3	.0493
7. Has much energy but doesn't know what to do	25.0	31.3	43.8	23.5	55.9	20.6	46.7	33.3	20.0	NS
8. Feels like walking out and keep on going	12.5	25.0	62.5	32.4	47.1	20.6	40.0	40.0	20.0	.0327
9. Can't stand this situation	6.3	56.3	37.5	58.8	32.4	8.8	53.3	26.7	20.0	.0067
10. Bored with life	12.5	37.5	50.0	58.8	32.4	8.8	60.0	20.0	20.0	.0043
11. Feels like crying, throwing oneself on the floor	25.0	50.0	25.0	67.6	26.5	5.9	80.0	13.3	6.7	.0150
12. Forgets things	18.8	43.8	37.5	29.4	58.8	11.8	60.0	26.7	13.3	.0287
13. Feels like someone calls him/her of knocks at door	50.0	31.3	18.8	79.4	14.7	5.9	100.0	0	0	.0229

Percentage of Respondents Reporting Three Levels of Problem Frequency by Age Subject: Mental Health Problems

MENTAL HEALTH PROBLEM	AGE SUBJECT: Under 30 (N=29) Never	Some-times	Often	30-44 (N=22) Never	Some-times	Often	45 and older (N-13) Never	Some-times	Often	p <
1. Can not sleep at night	31.0	41.4	27.6	59.1	27.3	13.6	46.2	46.2	7.7	NS
2. Headaches	31.0	48.3	20.7	36.4	31.8	31.8	23.1	61.5	15.4	NS
3. Feels nervous and tense	20.7	55.2	24.1	47.6	23.8	28.6	15.4	69.2	15.4	NS
4. Has chest, back or stomach pain	53.6	39.3	7.1	63.6	18.2	18.2	38.5	53.8	7.7	NS
5. Feels depressed	27.6	48.3	24.1	45.5	36.4	18.2	38.5	53.8	7.7	NS
6. Wants to yell, hit the wall or someone	41.4	34.5	24.1	63.6	18.2	18.2	53.8	30.8	15.4	NS
7. Has much energy but doesn't know what to do	24.1	44.8	31.0	36.4	50.0	13.6	30.8	38.5	30.5	NS
8. Feels like walking out and keep on going	27.6	37.9	34.5	27.3	45.5	27.3	38.5	38.5	23.1	NS
9. Can't stand this situation	24.1	55.2	20.7	63.6	13.6	22.7	61.5	30.8	7.7	.0142
10. Bored with life	27.6	44.8	27.6	63.6	13.6	22.7	69.2	23.1	7.7	.0291
11. Feels like crying, throwing oneself on floor	44.8	37.9	17.2	68.2	22.7	9.1	76.9	23.1	0	NS
12. Forgets things	20.7	48.3	31.0	50.0	45.5	4.5	38.5	46.2	15.4	NS
13. Feels like someone calls him/her or knocks at door	62.1	27.6	10.3	95.5	0	4.5	76.9	15.4	7.7	NS

Percentage of Respondents Reporting Three Levels of Problem Frequency by Education: Mental Health Problems

Mental Health Problem	EDUCATION SUBJECT: No School to 11th Grade (N=42) Never	Sometimes	Often	High School and More (N=23) Never	Sometimes	Often	p <
1. Can not sleep at night	38.1	35.7	26.2	52.2	39.1	8.7	NS
2. Headaches	21.4	47.6	31.0	47.8	39.1	13.0	NS
3. Feels nervous and tense	21.4	45.2	33.3	40.9	50.0	9.1	NS
4. Has chest, back or stomach pain	43.9	41.5	14.6	69.6	21.7	8.7	NS
5. Feels depressed	28.6	40.5	31.0	47.8	52.2	0	.0104
6. Wants to yell, hit the wall or someone	52.4	21.4	26.2	52.2	39.1	8.7	NS
7. Has much energy but doesn't know what to do	23.8	42.9	33.3	39.1	47.8	13.0	NS
8. Feels like walking out and keep on going	28.6	31.0	40.5	30.4	56.5	13.0	.0478
9. Can't stand this situation	42.9	38.1	19.0	47.8	34.8	17.4	NS
10. Bored with life	40.5	31.0	38.6	60.9	30.4	8.7	NS
11. Feels like crying, throwing oneself on the floor	54.8	33.3	11.9	69.6	21.7	8.7	NS
12. Forgets things	33.3	50.0	16.7	34.8	43.5	21.7	NS
13. Feels like someone calls him/her or knocks at the door	71.4	19.0	9.5	87.0	8.7	4.3	NS

Percentage of Respondents Reporting Three Levels of Problem Frequency by Yearly Income: Mental Health Problems

Mental Health Problem	YEARLY INCOME: 0 - $6,084 (N=25) Never	Some-times	Often	$6,216 - $10,080 (N=29) Never	Some-times	Often	$10,176 - $16,128 (N=9) Never	Some-times	Often	p <
1. Can not sleep at night	32.0	40.0	28.0	48.0	34.5	17.0	55.0	33.0	11.0	NS
2. Headaches	28.0	48.0	24.0	34.5	41.4	24.1	22.2	44.4	33.3	NS
3. Feels nervous and tense	36.0	32.0	32.0	17.9	53.6	28.6	44.4	55.6	0	NS
4. Has chest, back pain	37.5	50.0	12.5	55.2	34.5	10.3	77.8	0	22.2	NS
5. Feels depressed	32.0	40.0	28.0	34.5	44.8	20.7	49.4	55.6	0	NS
6. Want to yell, hit the wall or someone	48.0	32.0	20.0	55.2	24.1	20.7	55.6	33.3	11.1	NS
7. Has much energy but doesn't know what to do	20.0	44.0	36.0	37.9	37.9	24.1	33.3	66.7	0	NS
8. Feels like walking out and keep on going	20.0	44.0	36.0	34.5	31.0	34.5	33.3	66.7	0	NS
9. Can't stand this situation	28.0	52.0	20.0	55.2	24.1	20.7	55.6	44.4	0	NS
10. Bored with life	28.0	36.0	36.0	55.2	31.0	13.8	77.8	22.2	0	NS
11. Feels like crying, throwing oneself on the floor	56.0	32.0	12.0	58.6	31.0	10.3	77.8	22.2	0	NS
12. Forgets things	36.0	40.0	24.0	37.9	51.7	10.3	22.2	55.6	22.2	NS
13. Feels like someone calls him/her or knocks at door	64.0	28.0	8.0	82.8	10.3	6.9	88.9	0	11.1	NS

Percentage of Respondents Reporting Three Levels of Problem Frequency by Place of Birth: Mental Health Problems

Mental Health Problem	WHERE BORN: Puerto Rico (N=54) Never	Sometimes	Often	United States or LA (N=11) Never	Sometimes	Often	p <
1. Can not sleep at night	42.6	37.0	20.0	45.5	36.4	18.2	NS
2. Headaches	27.8	42.6	29.6	45.5	54.5	0	NS
3. Feels nervous and tense	24.5	49.1	26.4	45.5	36.4	18.2	NS
4. Has chest, back and stomach pain	51.9	35.2	13.0	60.0	30.0	10.0	NS
5. Feels depressed	33.3	44.4	22.2	45.5	45.5	9.1	NS
6. Wants to yell, hit the wall or someone	55.6	24.1	20.4	36.4	45.5	18.2	NS
7. Has much energy but doesn't know what to do	27.8	44.4	27.8	36.4	45.5	18.2	NS
8. Feels like walking out and keep on going	29.6	37.0	33.3	27.3	34.5	18.2	NS
9. Can't stand this situation	46.3	35.2	18.5	36.4	45.5	18.2	NS
10. Bored with life	48.1	27.8	24.1	45.5	45.5	9.1	NS
11. Feels like crying, throwing oneself on the floor	63.0	27.8	9.3	45.5	36.4	18.2	NS
12. Forgets things	35.2	50.0	14.8	27.3	36.4	36.4	NS
13. Feels like someone calls him/her or knocks at the door	77.8	14.8	7.4	72.7	18.2	9.1	NS

Percentage of Respondents Reporting Three Levels of Problem Frequency by Marital Status: Family Problems

Family Problems Identified As Existing	MARITAL STATUS						
	Single			Married			
	Never	Some-times	Often	Never	Some-times	Often	p <
1. Harsh discipline by parents	38.1	38.1	23.8	21.9	62.5	15.6	NS
2. Lack of discipline	20.8	33.3	45.8	6.1	51.5	42.4	NS
3. Lack of attention or neglect of children	22.7	31.8	45.5	6.1	33.3	60.6	NS
4. Poor understanding between parents and children	19.0	38.1	42.9	10.3	34.5	55.2	NS
5. Economic tensions	26.1	17.4	36.5	13.3	33.3	53.3	NS
6. Divorce	35.0	40.0	25.0	38.7	29.0	32.3	NS
7. Alcohol use	24.0	32.0	44.0	34.4	15.0	50.0	NS
8. Drug use	33.3	47.6	19.0	39.4	9.1	51.5	.0032
9. Emotional problem	36.8	36.8	26.3	34.4	40.6	25.0	NS

Percentage of Respondents Reporting Three Levels of Problem Frequency by Sex: Family Problems

Family Problems Identified As Existing	SEX						
	Male			Female			
	Never	Some-times	Often	Never	Some-times	Often	p <
1. Harsh discipline by parents	7.1	71.4	21.4	35.9	46.2	17.9	NS
2. Lack of discipline	15.4	30.8	53.8	11.4	47.7	40.9	NS
3. Lack of attention or neglect of children	15.4	30.8	53.8	11.9	33.3	54.8	NS
4. Poor understanding between parents and children	14.3	35.7	50.0	13.9	36.1	50.0	NS
5. Economic tensions	26.7	6.7	66.7	15.8	34.2	50.0	NS
6. Divorce	35.7	42.9	21.4	37.8	29.7	32.4	NS
7. Alcohol use	40.0	13.3	46.7	26.2	26.2	47.6	NS
8. Drug use	33.3	33.3	33.3	38.5	20.5	41.0	NS
9. Emotional Problem	37.5	37.5	25.0	34.3	40.0	25.7	NS

Percentage of Respondents Reporting Three Levels of Problem Frequency by Residence: Family Problems

Family Problems Identified As Existing	RESIDENCE									
	Florence Heights			Hampton Gardens			Town			
	Never	Some-times	Often	Never	Some-times	Often	Never	Some-times	Often	p <
1. Harsh discipline by parents	15.4	61.5	23.1	33.3	51.9	14.8	30.8	46.2	23.1	NS
2. Lack of discipline	0	50.0	50.0	14.3	42.9	42.9	23.1	38.5	38.5	NS
3. Lack of attention or neglect of children	6.7	46.7	46.7	10.7	32.1	57.1	25.0	16.7	58.3	NS
4. Poor understanding between parents and children	16.7	58.3	25.0	12.0	32.0	56.0	15.4	23.1	61.5	NS
5. Economic tensions	0	35.7	64.3	26.9	30.8	42.3	23.1	7.7	69.2	NS
6. Divorce	16.7	58.3	25.0	55.6	22.2	22.6	16.7	33.3	50.0	.0303
7. Alcohol use	13.3	40.0	46.7	35.7	14.3	50.0	35.7	21.4	42.9	NS
8. Drug use	28.6	28.6	42.9	48.1	18.5	33.3	23.1	30.8	46.2	NS
9. Emotional problem	18.2	63.6	18.2	46.2	34.6	19.2	28.6	28.6	42.9	NS

Percentage of Respondents Reporting Three Levels of Problem Frequency by Age of Subject: Family Problems

Family Problems Identified As Existing	AGE OF SUBJECT									
	Under 30			30-44			45 and older			
	Never	Some-times	Often	Never	Some-times	Often	Never	Some-times	Often	p <
1. Harsh discipline by parents	33.3	58.3	8.3	16.7	61.1	22.2	40.0	20.0	40.0	NS
2. Lack of discipline	7.7	38.5	53.8	5.0	65.0	30.0	40.0	10.0	50.0	.0077
3. Lack of attention or neglect of children	11.5	38.5	50.0	5.3	26.3	68.4	33.3	22.2	44.4	NS
4. Poor understanding between parents and children	8.7	43.5	47.8	6.3	37.5	56.3	40.0	10.0	50.0	NS
5. Economic tensions	8.0	28.0	64.0	18.8	25.0	56.0	45.5	18.2	36.4	NS
6. Divorce	19.0	52.4	28.6	27.8	33.3	38.9	81.9	0	18.2	.0042
7. Alcohol use	17.9	32.1	50.0	33.3	16.7	50.0	60.0	10.0	30.0	NS
8. Drug use	24.0	36.0	40.0	33.3	16.7	50.0	80.0	0	20.0	.0169
9. Emotional problem	26.1	43.5	30.4	37.5	43.8	18.8	54.5	18.2	27.3	NS

Percentage of Respondents Reporting Three Levels of Problem Frequency by Yearly Income: Family Problems

Family Problems Identified As Existing	YEARLY INCOME									p <
	0 - $6,084			$6,216 - $10,080			$10,176 - $16,128			
	Never	Some-times	Often	Never	Some-times	Often	Never	Some-times	Often	
1. Harsh discipline by parents	23.8	61.9	14.3	20.8	54.2	25.0	57.1	28.6	14.3	NS
2. Lack of discipline	8.3	45.8	45.8	8.0	44.0	48.0	42.9	42.9	14.3	NS
3. Lack of attention or neglect of children	8.3	50.0	41.7	13.0	13.0	73.9	28.6	42.9	28.6	.0410
4. Poor understanding between parents and children	14.3	42.9	42.9	15.0	35.0	50.0	12.5	25.0	62.5	NS
5. Economic tensions	17.4	26.1	56.5	23.8	19.0	57.1	14.3	42.9	42.9	NS
6. Divorce	28.6	47.6	23.8	39.1	26.1	34.8	60.0	0	40.0	NS
7. Alcohol use	20.0	20.0	60.0	34.8	26.1	39.1	42.9	28.6	28.6	NS
8. Drug use	22.7	40.9	36.4	39.1	8.7	52.2	71.4	14.3	14.3	.0276
9. Emotional problem	35.0	50.0	15.0	23.8	42.9	33.3	62.5	12.5	25.0	NS

Percentage of Respondents Reporting Three Levels of Problem Frequency by Where Born: Family Problems

Family Problems Identified As Existing	WHERE BORN						
	Puerto Rico			United States or Latin America			
	Never	Some-times	Often	Never	Some-times	Often	p <
1. Harsh discipline by parents	25.6	55.8	18.6	40.0	40.0	20.0	NS
2. Lack of discipline	10.9	41.3	47.8	18.2	54.5	27.3	NS
3. Lack of attention or neglect of children	11.4	31.8	56.8	18.2	36.4	45.5	NS
4. Poor understanding between parents and children	15.0	37.5	47.5	10.0	30.0	60.0	NS
5. Economic tensions	20.9	27.9	51.2	10.0	20.0	70.0	NS
6. Divorce	40.5	33.3	26.2	22.2	33.3	44.4	NS
7. Alcohol use	32.6	21.7	45.7	18.2	27.3	54.5	NS
8. Drug use	37.0	21.7	41.3	37.5	37.5	25.0	NS
9. Emotional problem	36.6	36.6	26.8	30.0	50.0	20.0	NS

Percentage of Respondents Reporting Three Levels of Problem Frequency by Marital Status: Community Problems

	MARITAL STATUS						
	Single			Married			
COMMUNITY PROBLEM ITEM	Never	Sometimes	Often	Never	Sometimes	Often	p <
1. Abuse or neglect of children	36.4	36.4	27.3	48.3	34.5	17.2	NS
2. Parents provide poor examples	26.1	30.4	43.5	24.2	36.4	39.4	NS
3. Dominating children	40.9	31.8	27.3	20.6	29.4	50.0	NS
4. Wife abuse	20.0	44.0	36.0	20.0	16.7	63.3	NS
5. Husband abuse	54.5	40.9	4.5	48.3	31.0	20.7	NS
6. Vandalism by community	26.1	43.5	30.4	35.3	32.4	32.4	NS
7. Vandalism by others	20.8	29.2	50.0	12.1	33.3	54.5	NS
8. Aggressive children	28.0	36.0	36.0	27.8	36.1	36.1	NS
9. Drug use	22.7	22.7	54.5	28.1	18.8	53.1	NS
10. Alcohol use	15.4	19.2	65.4	28.1	15.6	56.3	NS

Percentage of Respondents Reporting Three Levels of Problem Frequency by Sex: Community Problems

	SEX						
	Male (N=17)			Female (N=48)			
COMMUNITY PROBLEM ITEM	Never	Sometimes	Often	Never	Sometimes	Often	p <
1. Abuse or neglect of children	20.0	33.3	46.7	52.8	36.1	11.1	.0119
2. Parents provide poor examples	26.7	40.0	33.3	24.4	31.7	43.9	NS
3. Dominating children	23.1	30.8	46.2	30.2	30.2	39.5	NS
4. Wife abuse	7.1	28.6	64.3	24.4	29.3	64.3	NS
5. Husband abuse	38.5	30.8	30.8	55.3	36.8	7.9	NS
6. Vandalism by community	26.7	26.7	46.7	34.9	39.4	25.6	NS
7. Vandalism by others	12.5	31.3	56.3	19.0	31.0	50.0	NS
8. Aggressive children	18.8	43.8	37.5	31.1	33.3	35.6	NS
9. Drug use	20.0	26.7	53.3	23.2	17.9	53.8	NS
10. Alcohol use	23.5	11.8	64.7	22.0	19.5	58.5	NS

Percentage of Respondents Reporting Three Levels of Problem Frequency by Place of Residence: Community Problems

COMMUNITY PROBLEM ITEM	RESIDENCE									
	Florence Heights (N=16)			Hampton Gardens (N=34)			Town (N=15)			
	Never	Some-times	Often	Never	Some-times	Often	Never	Some-times	Often	p <
1. Abuse or neglect of children	42.9	42.9	14.3	50.0	31.8	18.2	33.3	33.3	33.3	NS
2. Parents provide poor example	7.1	35.7	57.1	35.7	35.7	28.6	21.4	28.6	50.0	NS
3. Dominating children	20.0	33.3	46.7	32.1	35.7	32.1	30.8	15.4	53.8	NS
4. Wife abuse	0	37.5	62.5	37.5	25.0	37.5	13.3	26.7	60.0	.0545
5. Husband abuse	42.9	42.9	14.3	56.5	30.4	13.0	50.0	35.7	14.3	NS
6. Vandalism by community	12.5	31.3	56.3	44.8	44.8	10.3	30.8	23.1	46.2	.0119
7. Vandalism by others	0	18.8	81.3	28.6	39.3	32.1	14.3	28.6	57.1	.0246
8. Aggressive children	6.3	31.3	62.5	41.9	38.7	19.4	21.4	35.7	42.9	.0273
9. Drug use	15.4	15.4	69.2	29.6	22.2	48.1	28.6	21.4	50.0	NS
10. Alcohol use	6.7	6.7	86.7	32.1	21.4	46.4	20.0	20.0	60.0	NS

Percentage of Respondents Reporting Three Levels of Problem Frequency by Age: Community Problem

COMMUNITY PROBLEM ITEM	AGE OF SUBJECT									
	Under 30 (N=29)			30-44 (N=22)			45-over (N=13)			
	Never	Some-times	Often	Never	Some-times	Often	Never	Some-times	Often	p <
1. Abuse or neglect of children	28.0	40.0	32.0	56.3	37.5	6.3	66.7	11.1	22.2	NS
2. Parents provide poor example	12.0	44.0	44.0	15.8	42.1	42.1	72.7	0	27.3	.0016
3. Dominating children	28.0	44.0	28.0	20.0	25.0	55.0	50.0	10.0	40.0	NS
4. Wife abuse	11.1	37.0	51.9	16.7	22.2	61.1	55.6	11.1	33.3	.0487
5. Husband abuse	58.3	37.5	4.2	41.2	29.4	29.4	55.6	33.3	11.1	NS
6. Vandalism by community	26.9	34.6	38.5	21.1	47.4	31.6	66.7	16.7	16.7	NS
7. Vandalism by others	7.7	30.8	61.5	10.5	42.1	47.4	50.0	8.3	41.7	.0125
8. Aggressive children	18.5	33.3	48.1	23.8	42.9	33.3	58.3	25.0	16.7	NS
9. Drug use	26.1	30.4	43.5	15.8	15.8	68.4	45.5	9.1	45.5	NS
10. Alcohol use	14.8	18.5	66.7	16.7	22.2	61.1	50.0	8.3	41.7	NS

Percentage of Respondents Reporting Three Levels of Problem Frequency by Education: Community Problems

COMMUNITY PROBLEM ITEM	EDUCATION						
	0-11th Grade (N=42)			High School + More (N=23)			
	Never	Sometimes	Often	Never	Sometimes	Often	p <
1. Abuse or neglect of children	43.3	43.3	13.3	42.9	23.8	33.3	NS
2. Parents provide poor examples	31.4	25.7	42.9	14.3	47.6	38.1	NS
3. Dominating children	31.4	25.7	42.9	23.8	38.1	38.1	NS
4. Wife abuse	24.2	27.3	48.5	13.6	31.8	54.5	NS
5. Husband abuse	45.2	41.9	12.9	60.0	25.0	15.0	NS
6. Vandalism by community	39.5	31.6	25.9	20.0	45.0	35.0	NS
7. Vandalism by others	23.7	28.9	47.4	5.0	35.0	60.0	NS
8. Aggressive children	30.8	38.5	30.8	22.7	31.8	45.5	NS
9. Drug use	27.3	21.2	51.5	23.8	19.0	57.1	NS
10. Alcohol use	24.3	16.2	59.5	19.0	19.0	61.9	NS

Percentage of Respondents Reporting Three Levels of Problem Frequency by Yearly Income: Community Problems

COMMUNITY PROBLEM ITEM	YEARLY INCOME LEVELS									
	$0-$6,084 (N=25)			$6,216-$10,080 (N=29)			$10,176-$16,128 (N=9)			
	Never	Some-times	Often	Never	Some-times	Often	Never	Some-times	Often	p <
1. Abuse or neglect of children	23.8	52.4	23.8	57.1	23.8	19.0	57.1	28.6	14.3	NS
2. Parents provide poor example	18.2	36.4	45.5	23.1	30.8	46.2	42.9	42.9	14.3	NS
3. Dominating children	31.8	45.5	22.7	20.0	20.0	60.0	37.5	25.0	37.5	NS
4. Wife abuse	17.4	47.8	34.8	13.6	13.6	72.7	37.5	25.0	37.5	.0445
5. Husband abuse	45.5	46.5	9.1	40.0	40.0	20.0	87.5	0	12.5	NS
6. Vandalism by community	21.7	43.5	34.8	30.8	34.6	34.6	62.5	25.0	12.5	NS
7. Vandalism by others	13.6	36.4	50.0	11.1	33.3	55.6	42.9	14.3	42.9	NS
8. Aggressive children	20.0	40.0	40.0	25.9	37.0	37.0	50.0	25.0	25.0	NS
9. Drug use	22.7	9.1	68.2	17.4	30.4	52.2	50.0	25.0	25.0	NS
10. Alcohol use	20.0	16.0	64.0	17.4	13.0	69.6	50.0	25.0	25.0	NS